The Scottish Government

Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review

Crime and Justice

EFFECTIVE SERVICES FOR SUBSTANCE MISUSE AND HOMELESSNESS IN SCOTLAND: EVIDENCE FROM AN INTERNATIONAL REVIEW

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Any errors in the report are the responsibility of the author.

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Summary

A Rapid Evidence Assessment of international literature on effective substance misuse services for homeless people was conducted to review best practice in other countries and determine if there were any lessons for Scotland. The review found that:

- The relationship between substance misuse and homelessness appears quite complex. There is strong evidence of a mutually reinforcing relationship between these two social problems. An experience of homelessness increases the risk of substance misuse among previously abstinent people, while entering into substance misuse also increases the risk that someone will become homeless. There is evidence that when someone is homeless and involved in substance misuse each problem compounds the other (Chapter 2).
- In Scotland, there is evidence that young homeless people, people with experience of sleeping rough and lone homeless people are characterised by higher rates of substance misuse than are found in the general population. There is evidence that parents and children in homeless families are either only a little more likely, or no more likely, to be involved in substance misuse than parents and children in the general population. The same pattern exists in England and in North America (Chapter 2).
- There is a strong association between the presence of mental health problems or severe mental illness among homeless people with substance misuse problems in Scotland. The same pattern exists in England, the EU, North America and Japan (Chapter 2).
- Services that are aimed solely at promoting abstinence among homeless people with a substance misuse problem tend to meet with quite limited success. There is evidence that many homeless people with a substance misuse problem either cease contact with these services before treatment or rehabilitation is complete or avoid such services to begin with. Attempts to use short stay detoxification services with homeless people have proven particularly unsuccessful (Chapter 3).
- When services pursue harm reduction or harm minimisation policies, rather than insisting on total abstinence, there is evidence that they are able to engage with homeless people with a substance misuse problem more effectively. In particular, there is evidence that harm reduction based floating support models used in the United States are able to promote and sustain stable living arrangements and ensure contact with services (Chapter 3).
- Homeless people with substance misuse problems have a range of needs that can include support with daily living skills, a requirement for mental health services and a

requirement for support in managing substance misuse. Their needs are often complex and services that focus on any one element of their need, be it substance misuse, mental health or housing related support, meet with less success than services that are designed to support all their needs (Chapters 2 and 3).

- There are three main models of resettlement for homeless people with a substance misuse problem. The first, the Continuum of Care or 'Staircase' approach, uses a series of shared supported housing settings that are intended to slowly progress service users towards independent living and abstinence. The evidence is that this model meets with limited success. The second, which is referred to in the US as the 'Pathways' Housing First model, uses intensive floating support to ordinary accommodation, with a strong focus on service user choice and a harm reduction approach to substance misuse. There is evidence that this is more successful and cost effective than the first model. The final model is a package of floating support provided through case management and joint working, which is the standard practice across Scotland. The evidence base on this approach is less developed than for some other models, though it follows the logic of both the flexible packages of support and harm reduction methods used by the more successful services (Chapter 3).
- There is no strong evidence on the effectiveness of preventative services to counteract potential homelessness among people with a history of substance misuse. Most models of prevention are generic, i.e. they are intended to counteract the risk of homelessness across many groups, including people with a history of substance misuse, rather than being particularly focused on one group (Chapter 3).
- The evidence base on alcohol misuse by homeless and potentially homeless people was very rich until the early 1980s when street drugs started to become much more widespread among street homeless and other homeless populations. Most research since that date has tended to focus on all forms of substance misuse, rather than dealing solely with alcohol, with the result that there is little recent evidence on services for homeless people that focus only on alcohol misuse. There is some evidence of older street homeless and hostel dwelling populations (people over 50) being more likely to be misusing alcohol and less likely to be using street drugs. However, among younger homeless people, the evidence is of use of alcohol alongside street drugs and other substances (Chapter 2).

Measuring effectiveness

The review also explored how the effectiveness of different service models for homeless people with a history of substance misuse was measured. Success for these services was defined in their own terms; for example if a service aimed to promote abstinence and independent living, achieving that was a successful outcome and not achieving it was a

failure. The evidence base on the success of some service models is much stronger than for others (Chapter 4).

There is a general lack of information about the extent to which successful service outcomes are maintained over time. For example, it is not always clear if a homeless person who has been resettled and whose substance misuse is either more controlled, or has ceased, at the point at which a service stops working with them has been able to sustain that position without the service's support. Only in the United States is there a tradition of longitudinal or 'tracking' research that looks at service outcomes over time and compares the outcomes of services by using Randomised Control Trials. This evidence, gathered in large, robust studies that take years to complete, is one of the drivers behind the adoption of flexible, comprehensive services that encompass greater user choice and harm reduction approaches in the US. The same methods raised questions about the efficacy of detoxification and rehabilitation services that did not offer housing related support, access to accommodation or help with mental health problems to homeless people. While joint working in service provision in Scotland follows many of the principles adopted by more successful services in the US, there is not a good evidence base on whether the positive outcomes achieved by services are sustained over time (Chapter 4).

Evidence on service success needs to be treated with a degree of caution because what is seen as 'success' is determined by a service's own goals. Thus, while flexible, comprehensive services with a harm reduction focus are more 'successful' than services aiming for abstinence in the US, their goals are less ambitious (Chapter 4).

Recommendations

The research has a series of broad recommendations. These recommendations encompass both service design and the assessment of service effectiveness (Chapter 5). In summary, these recommendations are:

- realistic service outcomes need to be set, these will be higher for some service users than others;
- harm reduction/harm minimisation models appear to meet with more success, though it needs to be borne in mind that their goals are more limited;
- the evidence base suggests a need for a mixture of services;
- longitudinal monitoring of service outcomes should be undertaken where possible;
- the evidence base suggests that service interventions may need to go on for some time, creating a need for a secure funding base;

- modification of generic services may be the best option in areas where numbers of homeless people with a history of substance misuse are low.

One of the messages from the review is that the pursuit of abstinence, independent living and paid work for all homeless people with a history of substance misuse may not be a realistic goal. Some individuals are highly vulnerable and have ongoing health, personal care and other support needs which may mean that they need long term service interventions and may not be able to live independently or have secure paid work. It is also evident that harm reduction and harm minimisation models are more effective at retaining engagement with homeless people with a substance misuse problem than services that insist on abstinence. However, there is also evidence that services that pursue abstinence do succeed with at least a minority of homeless people. This suggests a need for a mixture of services, or a flexible service model, that can accept when harm reduction and semi-independent living are the only realistic goals, but that also has the capacity to pursue abstinence and independent living as appropriate.

Service effectiveness cannot really be judged without some form of long term monitoring to see if positive outcomes are sustained, or whether people relapse into substance misuse and/or re-enter homelessness once support is withdrawn. There is also evidence that services themselves often need to be long term, which means that they may require quite long, securely funded contracts, in order to pursue sustainable success. It may not always be practical to develop specialist services for homeless people with a substance misuse problem in every area of Scotland, because the numbers of people in this group are relatively low in some rural areas. One option may be to develop wide-area services that cover several more rural authorities, another option is to modify practice in general homelessness and substance misuse services, as well as examine joint working where appropriate, to try to ensure that there is awareness of the needs among homeless people with a substance misuse problem.

About the research

An international Rapid Evidence Review focused on effective services for homeless people with a substance misuse problem was conducted for the Scottish Government by the Centre for Housing Policy at the University of York. The review looked at evidence from countries that are broadly comparable to Scotland, including the EU, England, Wales, North America and Australasia. Academic research, policy research and policy documents were searched using a range of databases. The review included documents that were not published in English (Chapter 1 and Appendix 1).

The review used a definition of substance misuse provided by the Scottish Drugs Forum to determine the range of issues it would examine. This definition was as follows: "Use of, and/or dependency on, psychoactive drugs that causes demonstrable harm, either for the

individual or society, in terms of negative health, social or economic effects and would usually apply to such use of illegal drugs, prescription drugs or alcohol." The definition of homelessness used for this review is that developed by the Homelessness Task Force. This includes people defined in current legislation as homeless persons and persons threatened with homelessness, people sleeping rough and other insecurely or inappropriately accommodated households.

1 Introduction

1.1 This report is based on an international Rapid Evidence Assessment (REA) covering service evaluations and research on services for homeless and potentially homeless people with a history of substance misuse. The review was commissioned by the Scottish Government to examine the range of services that are available in comparable countries and to look at how service effectiveness is measured, following a recommendation from the Homelessness and Substance Misuse Advisory Group (HSMAG). The main aim of the research was that it would make suggestions about which services from other countries might be suitable for Scotland and on how best, drawing on international experience, to measure the effectiveness and efficiency of these services.

1.2 The three main objectives of the REA review were as follows:

- To identify and review available evidence on service models and approaches that produce positive outcomes for people with substance misuse problems who are either homeless or at risk of homelessness.
- Outline and assess how positive outcomes in effective services are recognised and measured.
- Develop potential outcome measures for services.

1.3 The research involved two stages over the course of its six month timetable. The first stage formed almost all of the research effort and was focused on collecting and reviewing international evidence. The review was conducted by the Centre for Housing Policy with the assistance of the Centre for Reviews and Dissemination at the University of York. The methodology employed is detailed in **Appendix 1** of this report.

1.4 The review was focused on countries that were broadly comparable with Scotland. This included the EU, other European countries, Australasia, Japan, North America and England, Wales and Ireland (including Northern Ireland). Other countries were not included because comparison with Scotland is inherently problematic on a number of levels. The review encompassed papers and reports originally written in languages other than English and provision was made in the budget for translation. The single largest source of research and related information specifically focused on substance misuse and homelessness was the United States, this was followed by the work produced in Scotland and England, with studies from EU countries, Japan and Australasia being less common. The bulk of the most rigorous and systematic work was from the US and the only examples of longitudinal Randomised Control Trials (RCTs) were from the US. The databases searched encompassed medical, social and homelessness research as well as related policy documents (see Appendix 1).

1.5 The second, very much smaller, part of the research involved interviews with eight agencies across Scotland. This did not represent detailed fieldwork and only intended to help set the findings of the main part of the research in context. This work was primarily focused on ensuring that the report made logical recommendations in respect of which services might be suitable for Scotland and in respect of how best to measure service outcomes. There would be little point, for example, in recommending a service that was designed for an entirely different context to that found within Scotland (or within specific areas of Scotland),

because the model would be unlikely to fit. This material was too limited in scope to be included as part of the results reported here, especially as it was only focused on ensuring that the recommendations of the main study allowed for the Scottish context.

1.6 This review encompasses substance misuse as it relates to homelessness, services *specifically* designed for homeless people with substance misuse problems and the evaluation of those specific services. The review is not intended to describe or examine the nature and extent of all forms of homelessness, nor is it a document that is intended to describe, compare or analyse substance misuse in general, either in relation to Scotland or to anywhere else in the world. Equally, this review is not designed to describe or examine substance misuse services in general, nor to describe or examine homelessness services in general. This review is not an examination of evidence on the effectiveness of detoxification, rehabilitation, harm minimisation or harm reduction, *other* than in relation to services focused largely or entirely on homeless people with a substance misuse problem. Neither is this report is an examination of the effectiveness of homelessness prevention services, resettlement services, tenancy sustainment services or supported housing for homeless people, *other* than in relation to services focused largely or entirely on homeless people with a substance misuse problem.

1.7 The report is divided into five main chapters. This first chapter is the introduction, which describes the report and its methodology. Within Chapter Two, the links between substance misuse and homelessness are critically assessed by drawing on the international evidence base. Chapter Three presents a description of the types of services that are employed in comparable countries to Scotland, as well as within Scotland itself, and critically reviews the evidence on their effectiveness. The potential suitability of each of these services for Scotland is then considered. The following groups of services are reviewed:

- joint working or case management models based on interagency working delivering floating support to people in general needs housing;
- fixed-site clinics and residential detoxification models;
- one-site transitional housing and staircase/Continuum of Care models;
- permanent supported housing;
- intensive floating support services or 'Housing First' models that provide dedicated specialist workers and offer open ended support;
- preventative services.

1.8 Chapter Four looks at how service outcomes have been assessed across comparable countries, comparing and contrasting systems for monitoring performance. This fourth chapter then makes recommendations about how outcomes might be measured, including a draft outcome monitoring return which is included as **Appendix 3.** Chapter Five of the report contains the conclusions of the review.

2 THE LINKS BETWEEN HOMELESSNESS AND SUBSTANCE MISUSE

Introduction

2.1 This chapter reviews the evidence on the links between homelessness and substance misuse. Drawing on international evidence, it is argued that the relationship between substance misuse and homelessness is not a straightforward one. Substance misuse among homeless people is strongly associated with economic marginalisation, social isolation, alienation and, in particular, mental health problems. It is also argued that substance misuse is more closely linked with some groups of homeless people than others. The balance of evidence is that homelessness and substance misuse are mutually reinforcing. However, substance misuse, in itself, is generally not a necessary or sufficient condition for homelessness to occur, as other factors also appear to be involved.

Defining terms

2.2 This review employs the terms 'substance misuse' and 'homelessness'. It is recognised that the exact meaning of these terms is the subject of ongoing discussion and debate and it is not argued that the categorisations used for this review are in any sense definitive. However, it was necessary to set some clear boundaries for what the review did and did not encompass for practical reasons. What constitutes 'homelessness' and 'substance misuse' is in part a matter of individual perception, in part a matter of political interpretation and in part a matter of how services and legislation define these 'social problems', as well as being influenced by the culture of a society. The point at which poor housing situations are interpreted as 'homelessness' or the point at which alcohol consumption ceases to be merely 'drinking' and becomes 'substance misuse' are good examples of the kinds of debates that exist.

2.3 The definition of homelessness used for this review is that developed by the Homelessness Task Force. This definition embraces the following categories, which are not mutually exclusive:

- Persons defined in current legislation as homeless persons and persons threatened with homelessness, i.e. those:
    - Without any accommodation in which they can live with their families.
    - Who cannot gain access to their accommodation or would risk domestic violence by living there.
    - Whose accommodation is "unreasonable", or is overcrowded and a danger to health.
    - Whose accommodation is a caravan or boat and they have nowhere to park it.

- Those persons experiencing one or more of the following situations, even if these situations are not covered by the legislation:
    - Roofless: those persons without shelter of any kind. This includes people who are sleeping rough, victims of fire and flood, and newly-arrived immigrants.
    - Houseless: those persons living in emergency and temporary accommodation provided for homeless people. Examples of such accommodation are night shelters, hostels and refuges.
    - Households residing in accommodation, such as Bed & Breakfast premises, which is unsuitable as long-stay accommodation because they have nowhere else to stay.
    - Those persons staying in institutions only because they have nowhere else to stay.
    - Insecure accommodation: those persons in accommodation that is insecure in reality rather than simply, or necessarily, held on an impermanent tenure. This group includes:
        - Tenants or owner-occupiers likely to be evicted (whether lawfully or unlawfully).
        - Persons with no legal rights or permission to remain in accommodation, such as squatters or young people asked to leave the family home.
        - Persons with only a short-term permission to stay, such as those moving around friends' and relatives' houses with no stable base.
    - Involuntary Sharing of Housing in Unreasonable Circumstances: those persons who are involuntarily sharing accommodation with another household on a long-term basis in housing circumstances deemed to be unreasonable.

2.4 This review focuses on the *problematic* use of alcohol and/or other drugs among homeless people. The definition used for substance misuse in this report is that for 'problem substance use', as employed by the Scottish Drugs Forum: [1]:

> "Use of, and/or dependency on, psychoactive[2] drugs that causes demonstrable harm, either for the individual or society, in terms of negative health, social or economic effects and would usually apply to such use of illegal drugs, prescription drugs or alcohol."

2.5 This definition has been extended slightly for the purposes of this review to include solvent misuse. This includes the inhalation of gases from glue or other industrial products that would cause harm according to the criteria used in the SDF definition. While not intended as 'drugs', these substances can have psychoactive effects on those consuming

[1] http://www.sdf.org.uk/

[2] A psychoactive drug "possesses the ability to affect the mind, emotions, or behaviour" source: Oxford English Dictionary, see http://dictionary.oed.com/ .

them, as well as representing demonstrable risks to health. The definition was also extended to include the use of drugs intended for animals, such as Ketamine, although the review identified no direct research evidence on this in relation to homeless people.

2.6 For the purposes of the review, the consumption of moderate levels of alcohol by homeless people was not viewed as 'substance misuse'. Tobacco consumption, which can be very considerable among some groups of homeless people (Gill et al, 1996), was also not viewed as constituting 'substance misuse'.

2.7 Readers should note that the definitions employed in the review are wider than those sometimes used to describe either homelessness or substance misuse in other countries. For example, much of the EU and the US tend to define 'homelessness' as only including street homeless (rough sleeping) people and people in emergency accommodation such as direct access hostels or night-shelters. The studies reported on here all focus on problematic substance misuse, but the specifics of what is meant by that term may vary slightly. Studies that defined homelessness or substance misuse wholly or partially *outside* the definitions given above were excluded from the analysis.

Substance misuse and the causation of homelessness

Changing ideas about substance misuse and homelessness

2.8 Substance misuse has long been associated with homelessness. During the 1960s, an association was found between alcohol misuse, rough sleeping and homeless people who lived in hostels or shelters. This group were identified as overwhelmingly male, tending towards middle age and characterised by often never having been married or having experienced relationship breakdown. This pattern existed in Scotland, throughout the rest of the UK and was also evident in Europe and North America (NAB 1966; Priest 1970; Ross 1970; Priest 1971; Priest 1976; DHSS 1977; Borg 1978) .

2.9 During the 1980s and 1990s there was an increase in youth homelessness in much of the economically developed world, which seemed to be associated with illegal drug use (Klee 1996; Johnson, Freels et al. 1997; Fitzpatrick 1998; Klee and Reid 1998; Klee and Reid 1998a; Martijn and Sharpe 2006). Scottish research showed that young homeless people were more likely to be using illegal drugs, or using a combination of illegal drugs and alcohol, than older homeless people (Kershaw, Singleton et al. 2000; Owen and Hendry 2001). The same pattern emerged elsewhere in the UK and internationally (Craig and Hodson 2000; Coumans and Spreen 2003; Fichter and Quadflieg 2003; Fountain, Howes et al. 2003; Glasser and Zywiak 2003; Lempens, van de Mheen et al. 2003; Stax 2003; Teesson, Hodder et al. 2003; Kertesz, Larson et al. 2005; Rosen, McMahon et al. 2006).

2.10 Broadly speaking, research began to move away from the study of the relationship between alcohol and homelessness and towards substance misuse in general and homelessness in the 1970s. Research into alcohol use among homeless people did not cease, but it started to take place as part of research looking at a range of substance misuse that included illegal street drugs. Research focused solely on illegal drug use and homelessness also began to appear from that point onwards. Studies looking only at alcohol use among homeless people became quite unusual in the 1980s and remain quite unusual. This shift in

the focus of research reflected changes in homeless populations, whose use of illegal street drugs, in particular, increased from the 1970s onwards.

2.11 Evidence on substance misuse by homeless people in Scotland suggests two forms of substance misuse are quite widespread. The first is the misuse of alcohol, which the evidence suggests remains significant, and the second is the use of heroin, especially since the drug became very widespread across Scotland. However, there is evidence that at least some homeless people in Scotland engage in many and varied forms of substance misuse (Kershaw et al, 2000; Wadd et al, 2006).

2.12 Some research has looked for direct causal relationship between substance misuse and homelessness, i.e. evidence that people became homeless because of substance misuse. Marginalisation theory, a concept from American ethnographic research, argues that homelessness occurs at the point when the process of social, economic, psychological and physical deterioration, caused by substance misuse, results in someone losing control of their life (Coumans and Spreen 2003).

2.13 However, many studies suggested that the relationships between homelessness and substance misuse were often more complex. Some academics questioned the extent of the role of substance misuse had in causing some forms of homelessness and also raised questions as to whether, when someone was involved in substance misuse, this was always the *main* cause of their becoming homeless. The 'loss of control' arguments from marginalisation theory were not dismissed by this new evidence, it was more the case that a 'loss of control' due to substance misuse came to be viewed as one of *many* routes into homelessness. There were six main reasons for this:

- homeless people who were involved in substance misuse also tended to have high rates of mental health problems;
- some research suggested that substance misuse increased as a *consequence* of homelessness and that it sometimes arose after someone had become homeless;
- not enough homeless people had substance misuse problems for this to be the *sole cause* of homelessness;
- homeless people had other shared characteristics, like experiencing a disrupted childhood or a history of economic exclusion, alongside histories of substance misuse, if substance misuse was a factor, then perhaps these other shared experiences and characteristics were also factors;
- substance misuse was found to be much less prevalent among women in homeless families than among lone homeless people;
- associations were found between relationship breakdowns, changes in welfare systems, housing markets and labour markets and increases in homelessness, which again suggested other factors had roles in the causation of homelessness.

2.14 There is longstanding evidence that homeless people who are characterised by substance misuse are very frequently also characterised by mental health problems, both across Scotland and throughout the UK (Priest 1976; Shanks 1989; George, Shanks et al. 1991; Newton, Geddes et al. 1994; Sclare 1997; Watson 1999; Owen and Hendry 2001; Fountain, Howes et al. 2003; Kershaw, Singleton et al. 2003; Gilchrist and Morrison 2005; Wadd, Hutchinson et al. 2006). Elsewhere in the economically developed world, high rates of

mental health problems coupled with substance misuse problems, are also widely reported among street homeless and hostel dwelling homeless people (Fischer and Breakey 1991; Baum and Burnes 1993; Mossman 1997; Tanimoto, S. and M. Minowa 1998; Takano, Nakamura et al. 1999; Rosenblum, Nuttbrock et al. 2002; Fichter and Quadflieg 2005).

2.15 From the 1980s onwards, homeless people with both substance misuse and mental health problems began to be described as 'dual diagnosis' homeless people. This term has fallen out of favour in Scotland and elsewhere in the UK, and it has been replaced with the arguably rather ambiguous term, 'multiple needs'.

2.16 The presence of mental health problems makes understanding the causation of homelessness more complex. It became unclear whether or not substance misuse, rather than mental health problems, was causing homelessness, or whether it was some combination of both factors (Koegel, Burnam et al. 1988; Hertzberg 1992; Susser, Moore et al. 1993; Susser, Betne et al. 1997; Koegel, Sullivan et al. 1999; Fountain, Howes et al. 2003; Mallett, Rosenthal et al. 2005; Backer and Howard 2007; Mossman 1997; Lyon-Callo 2000).

2.17 Some research was criticised for not exploring whether or not substance misuse predated homelessness, *caused* homelessness, or arose as a *consequence* of homelessness. Some evidence suggested that experiencing homelessness appeared to be leading to substance misuse among people without prior histories of substance misuse (Cohen and Thompson 1992; O'Toole, Gibbon et al. 2004; Bousman, Blumberg et al. 2005).

2.18 In Scotland, as well as elsewhere in the UK, it was also the case that fairly large groups of homeless people were not reported to be misusing drugs or alcohol. For example, research among people sleeping rough and homeless people in hostels in Glasgow by Kershaw *et al* found that while 60% of men reported hazardous drinking behaviour and 25% of homeless people reported illegal drug use, one third were not involved in substance misuse. Another study in England by Gill *et al* found that 37% of people sleeping rough and hostel dwellers were using opiates and 36% were alcohol dependent, although in this sample only 16% were non-drinkers. Other UK studies found very high rates, but also found that substance misuse was not universal (Gill, Meltzer et al. 1996; Randall, Brown et al. 1996; Owen and Hendry 2001; Kershaw, Singleton et al. 2003).

2.19 Research had also found that lone homeless people in hostels and people sleeping rough tended to have other shared characteristics, besides substance misuse and mental health problems. These people were sometimes *more* likely to report growing up in relative poverty, disrupted childhoods, low educational attainment and a history of poor social and emotional support, than they were to report a history of substance misuse (Anderson, Kemp et al. 1991; Timmer and Eitzen 1992).

2.20 Substance misuse is directly linked to women's homelessness and family homelessness, because of the role that alcohol plays in male violence against women. Domestic violence is a significant cause of homelessness. There is also evidence, from women experiencing domestic violence, that substance misuse may be used as a coping mechanism (Scottish Women's Aid 2005). However, there is less evidence of substance misuse among homeless women with children than among some other groups of homeless people.

2.21 In Scotland, as well as elsewhere in the UK, many women become homeless with their children, with quite significant numbers also becoming homeless when they are

pregnant, often as a result of relationship breakdowns. Family homelessness, which is similarly dominated by adult women lone parents in Europe, North America and Australasia, is generally less likely to be associated with substance misuse than other forms of homelessness (Watson and Austerberry 1986; Bassuk 1990; Shinn 1997; Main 1998; Edgar and Doherty 2001; Tessler, Rosenheck et al. 2001; Pleace, Fitzpatrick et al. 2008). In a recent study in England, 11% of adults in homeless families self-reported any history of substance misuse, compared to 37% of lone young homeless people (Pleace et al. 2008). It should be noted however that this is a difference that appears to be linked to parents who have children with them in their household, lone homeless people, who are characterised by higher rates of substance misuse, can quite often have children with whom they have lost contact (Jones, 1999).

2.22 Among *lone* young homeless women and lone women sleeping rough or living in hostels, drug misuse appears comparable to that of men in the same situation. However, there is evidence that women are less likely to be involved in routine hazardous drinking, both in Scotland (Kershaw, Singleton et al. 2003) and elsewhere in the EU (Fichter and Quadflieg 2006).

2.23 Finally there is the evidence of other factors in the causation of homelessness. Changes to benefits, housing markets and economic downturns are widely seen as contributory factors in the UK, the EU and the US. There appeared to be structural elements within the causation of homelessness, it was not just a matter of individual characteristics and experiences (Timmer and Eitzen 1992; Shinn 1997; Main 1998; Pleace 1998; Shinn and Tsemberis 1998; Quigley and Raphael 2001; Fitzpatrick 2005).

2.24 There is a belief in some quarters that eviction of tenants involved in consumption or supply of illegal drugs by social landlords is a significant driver of homelessness in Scotland. The review found no evidence to suggest this is the case. Evictions by social landlords in Scotland and in other UK countries are very small in relation to overall levels of homelessness, and the main reason for eviction is rent arrears. For example, in 2003/4 there were 3,772 evictions by social landlords in Scotland (DTZ Pieda Consulting, 2004), including post-decee abandonments[3]. In the same year, 94% housing association and 98% of local authority evictions were reported as resulting from non-payment of rent (DTZ Pieda Consulting, 2004). In the same year, 57,397 households approached Scottish local authorities as homeless[4].

Evidence of more complex relationships between substance misuse and homelessness

2.25 Kemp et al explored data on the experience of homelessness among 877 drug users in Scotland (Kemp, Neale et al. 2006). Their research was particularly valuable because it was a longitudinal study. This allowed the associations between the characteristics, needs and actions of drug users, and their experiences of homelessness, to be explored over time.

[3] i.e. the household left before being removed.

[4] Source: HL1 Statistics

2.26 As Kemp et al note, people involved in substance misuse were likely to share characteristics that also tended to be found among people sleeping rough and lone homeless people in Scotland. These included:

- experiencing family disruption in childhood;
- physical or sexual abuse in childhood;
- poor exam marks, truancy and school exclusion;
- childhood conduct disorder;
- health problems;
- contacts with the criminal justice system.

2.27 Kemp et al report what they call a dynamic relationship between substance misuse and homelessness in Scotland. Drug users moved in and out of homelessness, 36% experienced homelessness, with 12% entering homelessness and another 14% exiting homelessness, between their first and second interviews. There was an association between recent injection of drugs (heroin), alcohol misuse, recent imprisonment, illicit income, having experienced disruption to family life during childhood, recent relationship breakdown, living apart from one's own children and an experience of homelessness (Kemp, Neale et al. 2006).

2.28 This research illustrates three complexities in determining the relationship between substance misuse and homelessness. The first point is obvious, in that while people involved in substance misuse are clearly at greater risk of becoming homeless than the general population, most do not become homeless. The second point is that the evidence shows that people involved in substance misuse and homeless people can have shared characteristics and experiences that extend beyond the points at which one population merges with the other, centred on a shared tendency to be economically excluded (see also Buchanan, 2004; Neale, 2006). The third point is related to the second, which is that substance misuse and homelessness are associated in *both* directions. It is not simply that substance misuse is associated with homelessness, homelessness is also associated with drug use, either can precede the other, the relationship *is not in one direction*.

2.29 Kemp et al interpret their results as showing that drug use is a catalyst for homelessness and homelessness is a catalyst for drug use, both problems 'mutually reinforcing' each other. They note:

> "It is also evident that drug misuse is a risk factor for homelessness and homelessness is a risk factor for drug misuse. In other words, using drugs can increase the likelihood that someone will become homeless, and conversely, being homeless can increase the likelihood of them using drugs" (Kemp and Neale *et al* p. 320).

2.30 Some American research has suggested very similar patterns. If substance misuse occurs, homelessness becomes more likely, similarly if homelessness occurs, substance misuse becomes more likely. The one can be a trigger for the other, the one can lead to the other, but the sequence in which this occurs is not a set one. Homelessness is both an *outcome* of drug use and a *catalyst* for drug use (Coumans and Spreen 2003). Longitudinal German research among street homeless people found that sustained homelessness and severe

alcoholism were associated with one another in this same, mutually reinforcing, way (Fichter and Quadflieg 2005).

2.31 Johnson et al, writing about the US, identifies four main schools of thought about the role of substance misuse in the causation of homelessness (Johnson, Freels et al. 1997):

- Social selection theory, also called 'social disability' or 'drift down' theories, which hold that substance misuse is one of several paths into homelessness: "Homelessness is viewed as being the end result of an extended process during which an individual's social and economic resources are gradually depleted as a consequence of substance abuse and other disabilities" (p.437).
- Social adaptation theory, which argues that substance misuse is more likely to be a result of having become homeless: "According to this view, abuse of alcohol and/or drugs is a means of adapting to life on the streets and may be a learned method of coping with the stresses of homelessness" (p.438).
- A 'self medication' argument, according to which a primary cause of homelessness is mental health problems and substance misuse arises because people attempt to manage their symptoms through alcohol and drugs.
- A 'socialisation' argument, which asserts that homelessness exposes people to a peer group who are involved in substance misuse and that they copy this behaviour to be accepted and receive social support. A common argument is that drug users tend to only have relationships with other drug users, thus their social and emotional supports 'reinforce' their substance misuse.

2.32 Johnson's research found that these various possible causal relationships were not mutually exclusive, i.e. there was evidence that they were *all happening*. Again, homelessness appeared to be both triggered by and triggering substance misuse. This research also found evidence that relationship breakdown, economic factors and a range of other issues were associated with homelessness. It was not just that the interrelationship between substance misuse was complex and multi-directional, homelessness involving substance misuse was also associated with all sorts of other individual characteristics and experiences.

2.33 Substance misuse could, as other research has indicated, also be more closely interrelated with mental health problems than with any other issue. Both mental health problems and substance misuse may be catalysts for homelessness and arise because of it, but beyond this, they may function as catalysts for one another and arise for reasons outside homelessness (Mossman 1997).

2.34 Very similar arguments have arisen in the US in relation to the causation of homelessness being linked to mental health problems. Initially, researchers assumed a simple causal link between the closure of long stay psychiatric facilities and a rise in mental health problems in street homeless and hostel dwelling populations.

2.35 A series of papers by psychologists and psychiatrists brought this assumption into question. These authors reported that little attention had been paid to these populations prior to the closure of long-stay institutions (i.e. they may have had the same high prevalence of mental health problems when all the asylums were still open). In addition, a wide range of other shared characteristics existed in these populations whose homelessness was supposedly 'caused' by their mental health problems, not the least of which were poverty and exclusion.

There was also evidence of structural causes of homelessness, such as changes in housing and labour markets in the US. Finally, there was evidence that experiencing homelessness *led* to mental health problems in individuals who had previously had good mental health (Cohen and Thompson 1992; Snow, Anderson et al. 1994; Mossman 1997; Shinn 1997; Shinn and Tsemberis 1998; Stojanovic, Weitzman et al. 1999; Lyon-Callo 2000; Snow and Anderson 2001).

2.36 International research on homeless populations with a history of substance misuse has found strong evidence of alienation from wider society and lack of emotional support, coupled with being in a state of economic exclusion (Pleace 2000; Snow and Anderson 2001; Zlotnick, Tam et al. 2003). Hartwell, in an American qualitative study of substance misuse and homelessness describes a group of homeless men with histories of substance misuse:

> "…the men come to their lives as homeless 'substance abusers' from the accumulation of all their lives. Their experiences are not going to change with three, six or nine months of substance use treatment. Instead, changes must be made at both structural and social service system levels to alter the life course of these men entrenched in their social role due to personal and institutional experiences. Without structural changes such as the creation of living wage jobs, affordable housing and an evaluation of the efficacy of social services...multi-problem populations such as homeless substance users will continue to grow…"(Hartwell, 2003, pp. 498-499).

2.37 Homelessness and substance misuse have been strongly associated with an absence of family relationships, friendships and sexual relationships in the US, one group of researchers noted that (Zlotnick, Tam et al. 2003):

> "Many researchers believe that the relationship between disaffiliation and homelessness is self-perpetuating. A homeless adult who has less support with family and friends and less contact with needed services is more likely to remain homeless" (p.592).

2.38 Scottish research on homelessness confirmed the applicability of these findings at national level. Rosenguard et al, in their examination of routes out of homelessness in Scotland, identified six pathways ranging from an individual sorting out their own housing need, receiving limited support, receiving more extensive resettlement support through to permanent supported housing (Rosengard et al. 2001). Work by the Glasgow Homeless Network found evidence of social isolation, personal trauma and emotional distress among homeless people (Collins and Phillips 2003; Glasgow Homeless Network 2006). Research by Ferguson, looking at employment programmes for homeless people in Scotland noted:

> "Homeless people often have multiple personal and social issues and need to have moved from crisis to stability before any real progress in terms of developing employability potential can be made" (Ferguson, 2004, p.17).

2.39 All these studies paint a picture of homelessness and substance misuse as mutually reinforcing conditions that are the result of sustained, multiple, compound disadvantage throughout childhood and adult life. There is evidence of sustained socioeconomic exclusion, isolation and alienation among homeless people with a history of substance misuse. There is

also evidence that it is lone homeless people and young homeless people, rather than all groups of homeless people, who are characterised by high rates of substance misuse.

2.40 These research findings have specific implications for service design. There are strong indications that services for homeless and potentially homeless people with a history of substance misuse need to be comprehensive and flexible, to reflect the diversity of need they will encounter.

Summary

2.41 Over the last 40 years the associations between substance misuse and homelessness have become progressively better understood. Research has moved from a position in which homelessness was seen as a consequence of substance misuse, mental health problems or some combination of the two and towards a position in which substance misuse and homelessness are seen as mutually reinforcing, interrelated, social problems. Those who experience homelessness or substance misuse tend to share characteristics and homelessness can be both an outcome of substance misuse and a catalyst for substance misuse. People who become homeless, who have no history of substance misuse, are at an increased risk of developing substance misuse problems. People who become involved in substance misuse are, in turn, at increased risk of experiencing homelessness. These populations are in addition characterised by poor social supports, negative experiences during childhood, poor educational outcomes, and sustained worklessness.

3 Service responses to substance misuse and homelessness

Introduction

3.1 This third chapter of the report describes the service responses to substance misuse and homelessness. Chapter 3 begins with an overview of service types, which the author has constructed using the evidence base, before moving on to consider each one and its potential usefulness for Scotland in more detail.

3.2 This chapter argues that the bulk of evidence points towards the relative efficacy of comprehensive, flexible services which do not require abstinence from service users. There is also some evidence that higher intensity services that use ordinary housing can be more effective than services using shared supported housing or institutional settings.

3.3 However, it is also noted that success is often *relative*. There is strong evidence that no one service that is being employed provides a guaranteed route out of homelessness and substance misuse. Some services are less successful, some more so, but a 'magic bullet' to deal with homelessness and substance misuse has not yet been found. Effective responses to substance misuse and homelessness may need to employ combinations of service types, rather than relying on any one model.

3.4 Success is always evaluated in terms of the extent to which a given service type achieves the goals it sets for itself. For some services, as is described below, this involves achieving independent living, abstinence and paid work for service users, for others the goals are more modest, centring on harm reduction and residential stability. In some cases, as is detailed below, evidence on service effectiveness is scarce. If a service is reported as being a 'success', it is a success in terms of the goals it has set for itself.

3.5 The prevention of homelessness is central to Scottish Government policy (Pawson, Davidson et al. 2007). A discussion of homelessness prevention among people with substance misuse problems can be found at the end of this chapter.

An overview of substance misuse services for homeless people

3.6 Services for homeless people with substance misuse problems follow one of two broad approaches. The first approach is to promote abstinence. The second approach involves either harm reduction or harm minimisation.

3.7 Abstinence can be pursued via detoxification services or through rehabilitation services. Detoxification tends to involve a relatively short (often residential) programme lasting 1-3 months and is focused on detoxing someone from alcohol and/or any drug they are addicted to or dependent upon. By contrast, rehabilitation services tend to offer longer more extensive programmes, using structured support and being concerned with social and economic reintegration, as well as with housing needs. Rehabilitation services may be

residential and programmes may be as long as 1-2 years. In rehabilitation services for homeless people, particularly in the US, peer support models such as the "12-step", faith-based, group session and "buddy" systems used by Alcoholics Anonymous, are relatively common (Herman, Galanter et al. 1991; Barrows 1998; Laudet, Cleland et al. 2004).

3.8 The second approach employs harm reduction and harm minimisation models. Harm reduction assumes that ending substance misuse can be a long and complex process, and the first priority is to try to minimise the damage to the individual (Bok 1998; McCoy, Devitt et al. 2003). Harm reduction has been defined by Lenton and Single (1998) in the following way:

> "a) the primary goal is the reduction of drug-related harm rather than drug use per se;
>
> b) where abstinence orientated strategies are included, strategies are also in place to reduce the harm for those who continue to use drugs; and,
>
> c) strategies are in place to demonstrate that, on the balance of probabilities, a net reduction in drug related harm is likely to occur."

3.9 Harm minimisation is not dissimilar to harm reduction, indeed the terms can be used interchangeably in some cases[5], though there is more emphasis on minimising risks to health and well-being associated with substance misuse. Thus a needle exchange service designed to reduce HIV and Hepatitis infection from needle sharing might be described as a 'harm minimisation' service.

3.10 Both harm reduction and harm minimisation policies came to particular prominence across Scotland and other UK countries as sustained attempts were made to contain the threat of HIV infection from needle sharing. Indeed, the role of HIV in producing a fundamental shift in substance misuse policy as it related to intravenous drug use is significant. Since that time, harm reduction has developed into what McKeganey *et al* describe as a 'distinctive social movement with its own international organization and annual conference lobbying in favour of a wide range of pragmatic drug policies' (McKeganey et al, 2004).

3.11 In broad terms, these approaches reflect different interpretations of what substance misuse is and how it can be dealt with. Services based on supporting abstinence tend to view substance misuse as governed by individuals' decisions and place emphasis on developing and sustaining a 'will to change' in each person. Criminal justice systems may use enforced abstinence in order to 'correct' what can be interpreted as a deliberate choice to misuse substances.

3.12 Services that follow a harm reduction or harm minimisation approach have a different ethos. Substance misuse is seen as both a product of, and something that contributes to, a whole range of other support needs (see Chapter 2). Harm reduction approaches have broader goals, centred on reducing or minimising harm to an individual, rather than being confined to simply stopping substance misuse (Lenton and Single 1998). Indeed, harm reduction or harm minimisation services may well have goals only to contain or partially control substance misuse at levels that are less harmful to an individual, rather than seek to stop substance misuse altogether.

[5] http://www.druglink.ltd.uk/harm_min.htm

3.13 Substance misuse services for homeless people tend to follow one broad approach or the other. Some services are intended to tolerate and manage substance misuse while some are intended to be intolerant of substance misuse. Services include everything from "wet" hostels for homeless people with alcohol misuse issues (Podymow, Turnbull et al. 2006), through to services that insist on total abstinence, withdrawing services if more than one relapse occurs (Sosin, Bruni et al. 1995). Services are also differentiated by whether they attempt management or cessation of substance misuse in isolation from other support needs, or whether they attempt to manage or promote cessation of substance misuse as part of general resettlement.

3.14 Figure 3.1 gives an overview of the service types that operate in the countries included in the Review and is based on the evidence examined for the review. In summary, the main service types found around the World are:

- joint working or case management models based on interagency working delivering floating support to people in general needs housing;
- fixed-site clinics, counselling centres and residential detoxification models;
- one-site transitional housing and staircase/Continuum of Care models;
- permanent supported housing;
- 'Pathways' models that provide dedicated specialist workers and offer open ended support.

3.15 Case management, or joint working, models in which packages of support are tailored to an individual's needs and delivered to them in their own homes by floating support services is the main approach within Scotland. These packages of support tend to involve several agencies, working in coordination. In urban areas of Scotland, this may involve the use of substance misuse workers who are specifically trained to work with homeless and/or potentially homeless individuals, such services are available in Glasgow and Edinburgh for example (see below). Elsewhere, joint working will probably involve substance misuse services that are intended for the general population. In some cases, there will be access to services that can cater for people with both substance misuse and mental health problems, in other instances such services are not available.

3.16 Service coordination or case management can be organised through a dedicated key-worker, though there are models where a panel of service providers are responsible for joint assessment, service coordination and delivery. Substance misuse issues are handled by either specialist homelessness teams or by the integration of mainstream services, but their input will be part of a coordinated package of care involving other agencies and will not be delivered in isolation. Harm reduction is the norm within this approach in Scotland and elsewhere in the UK. These services are shown in Figure 3.1 as 'joint working or case management' models.

3.17 Detoxification services for homeless people usually provide short stays in residential settings, during which someone is detoxified and then released back into the community. There are also isolated examples of attempts to manage detoxification without the use of residential services. These services are shown in Figure 3.1 as residential detoxification models and fixed-site clinics (which are designed for homeless people to attend but which do not provide accommodation).

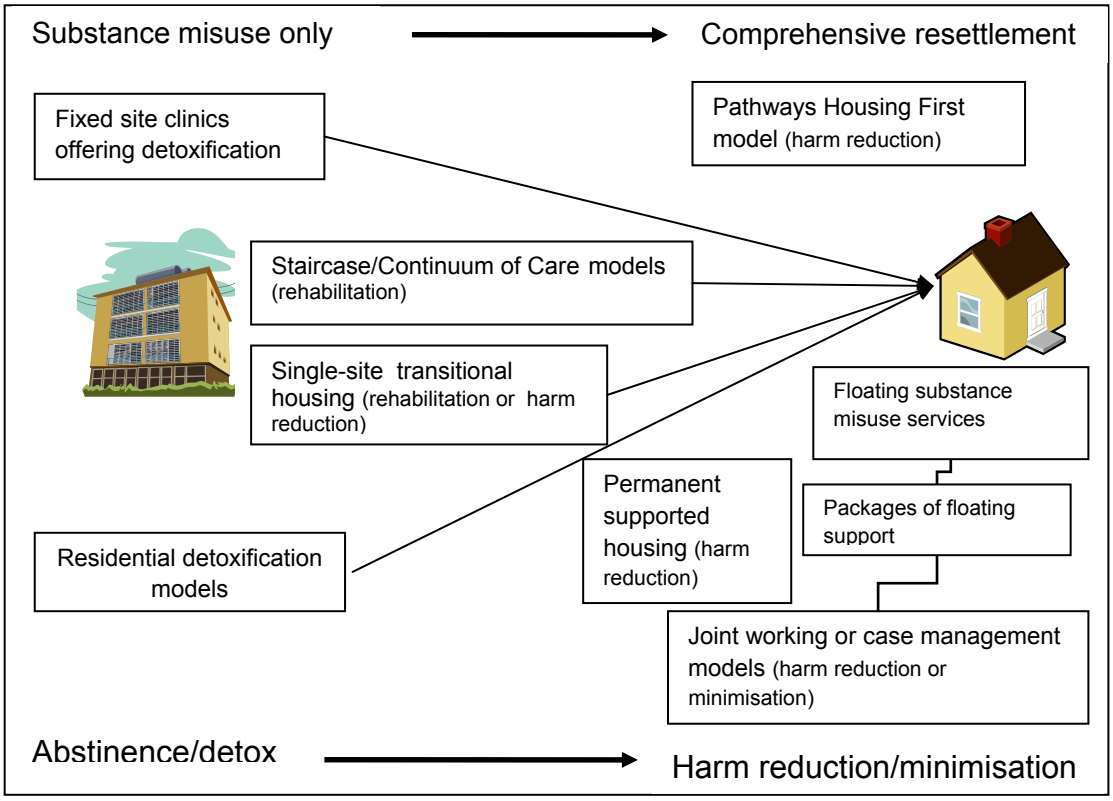


Figure 3.1: Overview of service types (derived from evidence base by author)

3.18 In addition, there are a range of fixed site services that focus primarily on promoting abstinence through rehabilitation. This rehabilitation services use a combination of structured support to promote abstinence and social and economic reintegration among homeless people with a history of substance misuse. Some services use detoxification as part of this process. Most of these services are residential and they include the 'staircase' and 'Continuum of Care' models from Sweden and the US, which provide different stages of accommodation through which a individual is intended to progress to independent living. These services are shown in Figure 3.1 as 'staircase/continuum of care' models.

3.19 Within Scotland and the UK, the staircase model is very unusual, although examples do exist. However, there is wider use of what can be termed single-site transitional housing, which rather than moving people between stages of accommodation, tends to aim to complete a process of resettlement within one supported housing setting. Single-site transitional housing can follow a rehabilitation model or a harm reduction or minimisation approach. These services are most commonly aimed at homeless people with an alcohol dependency. These services are shown in Figure 3.1 as 'single-site transitional housing'. Most of these services use a rehabilitation model, which again may include detoxification as part of the process of rehabilitation, but there are examples that use harm reduction or harm minimisation models.

3.20 Permanent supported housing has no resettlement function it is intended to provide a home for life (Figure 3.1). This form of supported housing is employed, in Scotland and in

other countries, when support needs or levels of risk are judged to be too great to allow independent living. This form of support is unusual. Most current examples appear to follow a harm reduction or harm minimisation approach.

3.21 The Pathways Housing First model uses direct provision of extensive, dedicated and open-ended support by a specially trained worker. This model, which has its origins in the support of people with severe mental illness in the community, provides more intensive forms of support than case management. It is explicitly designed to promote independent living in general needs housing among people with higher levels of need. The service follows a harm reduction approach. This service type is shown in Figure 3.1 as the Pathways Housing First model.

Joint working and case management models

Description

Case management and joint working models in Scotland and the UK

3.22 By the 1990s it was clear that allocation of social housing to homeless people characterised by support needs, such as mental health problems and substance misuse, was ending in failed or abandoned tenancies across the UK. Fragmented, uncoordinated, mainstream health, housing and social care services were not proving effective in meeting the needs of homeless people with support needs (Pleace 1995; Pleace and Quilgars 2003). In particular, there was a widely perceived failure of fragmented services in meeting the complex needs of homeless people with substance misuse problems (O'Leary 1997; Kennedy, Barr et al. 2001; Neale 2001; Neale and Kennedy 2002; Randall and Drugscope 2002). As noted in Chapter 2, while there is evidence that social landlords resist granting tenancies to homeless people with a history of substance misuse (Pleace *et al*, 2007), there is no clear evidence that evictions by social landlords, or action by criminal justice services, of people caught dealing drugs is a significant cause of homelessness.

3.23 A process of closure of long-stay homeless hostels has occurred throughout the UK. This was a result of evidence and experience that showed that these hostels were poor quality 'warehouses' for lone homeless men, in which few supports were available and from which there was little prospect of resettlement (Dant and Deacon 1989; Glasgow Homelessness Network 2003). A combination of smaller, specialised supported housing and case-managed resettlement using general needs housing, was developed to replace these hostels in Scotland (Glasgow Homeless Partnership 2002).

3.24 Originally, models for resettling and supporting homeless people with support needs were focused on coordination of local authority services, which essentially involved ensuring appropriate housing management and social work services were in place. A worker might also provide low level emotional and practical support, such as debt management and help with daily living skills, though it was unusual for any direct support to exceed one or two

hours a week. A few councils also developed specialist floating support services, for example focusing on homeless people with mental health problems, or young homeless people (Pleace 1995).

3.25 These models were based on the case management concept from community care. Essentially, this refers to a trained worker, or team of workers, who coordinate access and provision of care and support services to meet the needs of an individual client or household. The intention is that the case management process creates a package of services that is tailored to individual need. The model assumes that need is *varied* and *potentially complex* and that *several different services* may potentially be required for each individual. This model is also referred to as joint assessment, joint referral or sometimes as 'joint working', but it always shares one basic characteristic, which is that services are arranged around an individual's needs in a coordinated way, often via a dedicated worker.

3.26 Case management is the basis of joint working across welfare services and is the basic mechanism for delivering support to people in general needs housing in the community. It lies at the heart of current Scottish and other UK countries responses to substance misuse and homelessness (Kennedy, Barr et al. 2001; Randall and Drugscope 2002). There are three broad types of case management:

- trained case managers who assess individuals and arrange packages of care and support at first contact, but who do not work with a service user on an ongoing basis;
- individual key workers who provide low level support, the bulk of which is focused on arranging access to services and acting as an advocate on behalf of their service user with other service providers;
- models of case management in which an interdisciplinary team holds case conferences and collectively determines the package of care and support a service user should receive, this might be used for particularly high-needs groups.

3.27 Of these three broad types, the second and the third are probably the most common forms of joint working across homelessness services found within Scotland and the other countries in the UK (Drugs Prevention Advisory Service 1999; East Ayrshire Council 2001; Kennedy, Barr et al. 2001; Scottish Executive Health Department 2001; Edinburgh City Council 2002; Glasgow Homeless Partnership 2002; Randall and Drugscope 2002; Highland Council 2003). Services tend to follow a harm reduction or harm minimisation approach.

3.28 A number of changes occurred after 1997 in Scotland and elsewhere in the UK. Issues like people sleeping rough and homelessness were increasingly defined not simply as exclusion from housing, but as the result of compound disadvantage, as an exclusion from mainstream society, health and well-being and from economic opportunity and paid work, a situation of 'social exclusion' (Randall, Brown et al. 1996; Pleace 2000).

3.29 This agenda led to case management/joint working for homeless people in its current form. The most developed examples of case management centre on coordinating a wide range of services. As need becomes more complex the number of agencies involved can increase (Pleace and Quilgars 2003). Case management is broadly focused on meeting the following forms of need through *service coordination*, although practice varies somewhat across specific approaches:

- housing needs (via general needs social rented sector accommodation);
- financial needs (via benefits system and support with financial management from a worker);
- education, training and employment needs (via Job Centre Plus, employment, education and training services);
- physical health (via GP registration or use of specialist NHS services);
- substance misuse (via GP, specialist drug and alcohol services and mainstream drug and alcohol services, peer support schemes);
- mental health (via GP, specialist services and mainstream community mental health services);
- management of any anti-social behaviour and potential offending (via specialist workers or probation and related services);
- personal care needs (via social work departments);
- social and emotional support (via tenancy sustainment workers, may also include peer-provided social support);
- training and support in daily living skills, such as household management (via tenancy sustainment workers);
- advocacy on behalf of a homeless person, help with dealing with forms and other aspects of arranging access to services, via tenancy sustainment workers).

3.30 Within Scotland, the most widely used models have the following components

- coordinated assessments and service delivery involving combinations of social housing, social care, tenancy sustainment and other housing support services and NHS Scotland services aimed at all homeless people;
- integration of community substance misuse services within this coordinated assessment and service delivery framework, in the largest cities this includes *specialist* homelessness substance misuse services (Edinburgh City Council 2002; Glasgow Homeless Partnership 2002; Highland Council 2003):.

Examples of Scottish services

3.31 The Glasgow Homelessness Partnership was established in October 2002, bringing together Glasgow City Council, Greater Glasgow NHS Board and the Glasgow Homelessness Network, the umbrella organisation who represent the voluntary sector in the city. The partnership was created explicitly to provide what were termed "integrated user-centred services", through employing joint assessment and joint working. Nine Community Casework Teams were established across Glasgow, to provide assessment services. These

combined teams worked jointly with a range city-wide specialist services and with mainstream housing, social work and NHS Scotland services. Joint training and a mechanism for service user involvement, called the Service User Involvement Network, are in place to enhance the effectiveness of the Glasgow Homelessness Partnership in meeting the needs of homeless people (Glasgow Homeless Partnership 2002).

3.32 Substance misuse issues are handled through the use of a specialist team called the Homelessness Addiction Team. Part of the Glasgow Homelessness Partnership, this team provides a joint social work and health multi disciplinary addictions team which provides psychiatric and psychology services, occupational therapy, medical, social workers and nursing staff. The team has the capacity to prescribe and undertakes generic addiction work, substitution of managed methadone scripts for heroin users and the management of health problems, such as alcohol related brain damage (Morrison, Gilchrist et al. 2003; Gilchrist and Morrison 2005).

3.33 The team works with homeless people who may be rough sleeping, in emergency or temporary accommodation or within hostels. They also work with a variety of voluntary sector providers of supported accommodation and, will arrange for residential or community detoxification at all times working closely with other agencies. The team has the capacity to manage homeless people with both mental health problems and substance misuse issues through its own psychiatric resources, though the Glasgow Homelessness Partnership also includes a dedicated Homeless Mental Health Team to which they can make referrals. Once an individual or household has been re-housed by other members of the Glasgow Homelessness Partnership, the Homelessness Addiction Team refers individuals on to the city's mainstream community drug and alcohol services.

3.34 Case management also underpins Glasgow's programme to close down its long stay homeless hostels. In 2002, the Glasgow Homelessness Partnership submitted a 5-year Hostel Closure and Re-provisioning Plan to the Scottish Executive (now the Scottish Government), which agreed to fund the closures and the provision of alternative services. Many of the residents of these hostels had substance misuse issues and/or mental health problems as well as a range of other needs (Glasgow Homelessness Network 2003).

3.35 As some former residents have high levels of need, they are leaving the hostels and entering a variety of smaller, more specialised, supported housing, models based on addictions, young person's projects, mental health and continuing drinkers projects, some of which has a transitional function and some of which is permanent. Glasgow has also developed community addiction services with the voluntary sector which work with individuals settled into their own accommodation but who require ongoing alcohol support. The city has also committed resources to commissioning floating support models. These include "sticky" services which stay with the individual through their homeless career via prison or hospital, through to lower level housing support to assist with socialisation and or financial management. Following initial joint assessment, one of the five housing support teams provides a low intensity service that includes brokering and maintaining appropriate packages of care and support, drawing on NHS Scotland, housing association, social work and voluntary sector services. Many former residents are being resettled in the community using this case management model.

3.36 Case management also operates within Edinburgh. One example of the model in practice is the Access Point, which is a fixed site office designed primarily for people

sleeping rough and those at risk of homelessness. This service provides joint assessments and interagency referral for NHS Scotland, social work and social landlord services under one roof. Another branch of this service operates at the city's Cowgate Clinic[6].

3.37 The Homeless Outreach Project Addiction Team within Edinburgh is part of this case management framework. The team works primarily with people sleeping rough and those who are within hostels, mainly working from referrals from other agencies. A combination of drug and alcohol workers and two Community Psychiatric Nurses (CPNs) is used, alongside peer support group work and referral and access to NHS detoxification services. Again, as is the case in Glasgow, the addictions team is part of a network of services in which client details are shared and a coordinated package of care is created to attempt to meet needs. Services are organised and coordinated under one umbrella in an attempt to maximise effectiveness[7].

3.38 In Highland, homelessness services are centred around a day centre and housing office in Inverness. The daycentre offers housing advice, a GP service, a Homeless Persons (practice) Nurse and a CPN service. Assessments can be conducted for social housing, social work and NHS services, as well as services provided by voluntary sector organisations. This joint working model mirrors those found in Edinburgh and Glasgow with one exception, there is no specialist substance misuse service focused on homeless people. Instead, referrals are made to mainstream substance misuse services (Highland Council 2003) .

3.39 In Fife, homelessness services are grouped around four fixed site coordinated services called "Home4good" centres. Each centre is provided via the Fife Homeless Group, which includes the council, NHS Fife, Fife Homeless Forum (including representatives from the voluntary sector and homeless people using services) and the Fife Drug and Alcohol Action Team. The range of services available within each centre includes: housing advice; homelessness assessments and temporary accommodation services; employment, education and training services and access to substance misuse services.

3.40 In July 2005, Fife Drug and Alcohol Action Team received NHS Scotland funding to support substance misuse services for "hard to reach" homeless people, including people sleeping rough. The Fife Homelessness and Substance Misuse service was created, providing both outreach services and fixed-site services at the four "Home4good" centres across Fife. The service includes counsellors and a CPN. The service was constructed out of three Fife based substance misuse services for homeless people and young homeless people through a coordinated bid for NHS Scotland funding (Doherty and Stuttaford 2007).

3.41 Case management elsewhere in the UK tends to closely follow the models used in Scotland. As in Scotland, the likelihood that dedicated substance misuse teams specifically for homeless people will operate as part of a package of services declines as population size and the number of homeless people in an area reduces. As in Highland, more rural parts of Scotland, Wales and England do not tend to have specialised substance misuse services because the need does not exist at sufficient levels to make such services appear to offer good value for money.

[6] See http://www.homelessedinburgh.org/

[7] http://www.hopuk.org/addictions.asp

3.42 Within the UK, the use of a broad harm reduction approach within case management or joint working approaches is widespread. There are operational limits to this tolerance however. If someone is caught or convicted of dealing drugs or is involved in anti-social behaviour related to substance misuse, either can result in eviction from social housing and services disengaging with that individual. The same is true in respect of actual or threatened violence against staff.

3.43 These homelessness services are not restricted to any specific group of homeless people. They could be accessed by former rough sleepers, lone homeless people, women with children or two parent households.

Case management and joint working in other countries

3.44 Models of case management in US homelessness services differ slightly from the models used in the UK. As noted by (Bradford, Gaynes et al. 2005), there are two broad models:

- the 'broker' model which employs a dedicated worker whose role it is to coordinate (otherwise fragmented) mainstream and homelessness services to create an appropriate range of support;
- the Assertive Community Teams or Intensive Clinical Model, where the role of the worker or workers can include referral to other services and joint working with those services, however, the worker is either the major source of support and/or care or one of the main sources of support and/or care, which is a model employed in intensive floating support services in the US, including 'Housing First' models, which are discussed later in this chapter.

3.45 Examples of the Assertive Community Team or Intensive Clinical model in the evidence base are often found within intensive floating support services that also include general needs housing. The use of these models is explored under the discussion of intensive floating support and 'Housing First' models below. However, there are some examples of freestanding services.

3.46 The case management model is less common in the EU. This is in large part because interventions tend towards the use of staircase model, particularly targeted on street homeless populations (see below).

Evidence of effectiveness

3.47 Case management to provide a package of support to homeless people is the default form of homelessness provision across Scotland. The details of how this is arranged and the range of service providers involved varies from place to place, but some degree of joint working and joint assessment, is in place everywhere in which homelessness exists as a numerically significant social problem.

3.48 Given its extent, the evidence base on case management and joint working models specifically related to homelessness is surprisingly thin. In some senses, this is a result of this approach being a near universal orthodoxy, in that because no significantly different approach is employed elsewhere, relatively few questions are raised about the current approach. In addition, the models of case management, while following shared general principles of operation, tend to differ markedly in the detail of their operation, so that a review of any one set of working practices may not be generally applicable. It is certainly the case that available guidance focuses entirely on joint working and case management approaches (Kennedy, Barr et al. 2001; Randall and Drugscope 2002).

> "Developing partnerships provides benefits not only in terms of strategic planning but also on an operational level. Developing external relationships enables access to the range of organisations working on drug and homelessness related issues, both to the organisation and to service users" (Britton and Pamenja 2000, para 2.1) .

3.49 The problem of substance misuse among homeless people is seen as a combination of support needs that require a joined-up approach. Service failure is associated with failing to work together and failing to assemble the correct package of services (Kennedy, Barr et al. 2001; Neale 2001).

3.50 It can therefore be argued that the debate on responses to substance misuse and homelessness in Scotland and the UK has been treated as if it was effectively over. The only response is a coordinated package of care, so there has not been felt to be a need to compare that response with any other alternatives, such as fixed-site treatment-only services.

3.51 As a result, what research there is tends to focus on overcoming impediments to effective joint working and case management, with nothing really criticising the underlying logic of this approach. Indeed, much of what has actually been written on the specific subject of homelessness and substance misuse is actually *guidance*, rather than research.

3.52 The main operational problems in case management reported by research and guidance in UK are:

- resource limits which either limit access to required elements of care, housing or support or which mean those resources are not present; and
- difficulties in relation to interagency cooperation.

3.53 Resource limits in one or more sectors are often reported as creating problems in joint working and case management. The moment a required service input is not available, or is only available after a sustained wait, there is evidence that service effectiveness begins to decline (Scottish Executive 2003). The most commonly reported problems in relation to homeless people with a history of substance misuse are twofold:

- lack of suitable social housing or other affordable housing options;
- problems with accessing substance misuse services, including general resource levels and services that are not designed for people who have both mental health problems and substance misuse problems.

3.54 The underlying logic of the case management or joint working approach, a multiple-agency response to multiple needs, is undermined as soon as any service component is

missing. While these two problems are the most commonly reported within Scotland and in other UK nations, *any* lack of access to services might contribute to wider service failure (Homeless Link 2002; Taylor 2003) .

3.55 Recent research looking at the needs of people with substance misuse and mental health problems in Scotland (Hodges, Paterson et al. 2006), while not specifically focused on homelessness, has identified serious problems with interagency working for this group. Among their findings on people with substance misuse and mental health problems, Hodges *et al* noted that:

> "The structure of existing services and their service philosophies were considered by many as creating barriers for co-morbid[8] service users who might need input from a number of different service providers. Reports suggested that traditional trajectories rather than client-centred thinking often influenced decision making about approaches to service users. As a result, there were debates between services as to who should take responsibility for service users with different presenting problems". (Hodges, Paterson et al. 2006, p.68)

3.56 There can be particular problems in rural areas of Scotland and other countries in the UK. These problems essentially relate to the numerical scale of homelessness within those areas. Some services, such as substance misuse services specifically geared to the needs of homeless people and formerly homeless people are very difficult to justify in contexts in which there may only be a few homeless people presenting with substance misuse in a given year. A dedicated service cannot be justified economically, but this creates either a situation in which reliance on general services is required, which may be less suitable for homeless people (Bevan and Rugg 2006).

3.57 Networks for joint working also have to be relatively broad and easily accessible. For example, social landlords need to be able to access specialised services when they are housing people with a history of substance misuse, if these social landlords do not know where to go for help, they may see little option but to refuse to house certain groups of people, or to resort quickly to eviction when problems arise (Pleace, Quilgars et al. 2007) .

3.58 In the US, 'brokering' models of case management involve trying to connect fragmented and variable services to one another to create a package of support. There are important structural differences in that the US lacks a significant social rented sector, while health care that is free at the point of delivery is restricted. Some American studies link poor health and access to medical services among homeless people to lack of health insurance, (see for example: Appel, Ellison et al. 2004; O'Toole, Pollini et al. 2007; Stein, Andersen et al. 2007). Joint working and case management models cannot really function well in a context in which there are not the range of appropriate resources to draw upon.

3.59 This has created a marked tendency for US service responses to substance misuse among homeless people to offer 'all-in-one' responses that attempt to meet housing need, personal care needs, health needs, employment, education and training issues and a host of

[8] 'co-morbid' is sometimes used as an alternative term to 'dual diagnosis' or 'multiple needs', all refer to someone with both substance misuse and mental health problems.

other support needs alongside substance misuse, such as some Continuum of Care and Housing First models (see below).

3.60 Failure to cooperate and participate in joint working or case management models used to be relatively widespread. Agencies were unused to models of shared working fifteen years ago and there were widespread difficulties in establishing first strategic joint working and then service delivery level coordination between social housing, social care and health services. Various studies across the UK identified the following key issues (Watson 1997; Cameron, Harrison et al. 2001):

- a lack of shared language and a tendency for professionals to prioritise needs in ways that were associated with their own training, rather than there being a more holistic attempt at assessment of need;
- attempts at cost-shunting or moving responsibility away from a given service and pushing onto another service;
- problems in joint working when there were marked differences in professional status between the parties involved;
- success or failure being overly dependent on personalities and personal relationships between professionals;
- general resource constraints meaning that key parts of service provision required for joint working were not accessible.

3.61 Interagency cooperation within the field of homelessness is now an established operational norm across Scotland. However, these kinds of issues do sometimes remain, the nature and extent of problems varying between locations (Bevan and Rugg 2006).

3.62 Since joint working has sometimes been difficult to establish in Scotland and across the UK, researchers' attention has been focused on solving problems in joint working. However, it is not clear that successful joint working is providing lasting solutions for homeless people with a history of substance misuse. It is known that homelessness associated with substance misuse is a multifaceted problem that requires a multifaceted response, so if all inputs are in place, the outcome *should* be good. However, there is little hard evidence demonstrating that effectiveness has been enhanced. What data there are tend to be confined to services own records or collected self-reporting forms, which can be problematic sources of information, and there is a lack of longitudinal monitoring to determine whether or not service outcomes are sustained (see Chapter Four).

3.63 In the US, lack of interagency cooperation is not identified as a particular issue. However, there is some evidence that substance misuse services tend to quite often require total abstinence from service users, with some requiring evidence of abstinence in advance of working with an individual (Sosin, Schwingen et al. 1993; Sosin and Yamaguchi 1995). This may place limits on joint working with other services, because of the limited accessibility of abstinence-based service models (see below).

3.64 Most Scottish and UK examples of joint working and case management tend to set their own operational limits. In those instances in which the risk to an individual's well-being, or those around them, is judged to be too great to be effectively managed in the community, there is a tendency to use permanent supported housing. This is not always an option however, because such specialised resources do tend to be confined to cities (Bevan

and Rugg 2006). By extension, though not really drawing on any clear research evidence, it might be that case management of homeless people with higher needs cases is more problematic in rural areas and those areas without specific resources.

Suitability for Scotland

3.65 Joint working and case management are the operational norm throughout Scotland. The extent of joint working may vary between areas, but anywhere the process is not fully established the intention is that it will be employed. The available evidence base suggests little reason to question its underlying logic, when the required services and correct degree of interagency cooperation are in place, though there is less robust information on success rates than would be ideal. As is discussed below, there is some evidence from the US that the 'Housing First' model may provide a means of enhancing effectiveness as well as a mechanism by which people with very high needs can be resettled into the community.

Fixed-site detoxification services

Description

3.66 These services offer detoxification for homeless populations. Such services operate from a fixed site, such as drop-in clinic or a daycentre, or employ a residential setting. Fixed sites are necessary because of how substance misuse is dealt with by these services. Services that provide detoxification require beds, staff to monitor and administer drugs and other forms of support. Some services have outreach teams that seek to recruit homeless people from the street, shelters or hostels (Orwin, Goldman et al. 1994; Orwin, Garrison-Mogren et al. 1999; Bradford, Gaynes et al. 2005; Alford, LaBelle et al. 2007; Sosin and Durkin 2007).

3.67 These services either employ a medical model of detoxification, a group therapy and/or individual therapy approach based on supported abstinence. There are models that are residential that employ strict rules and intensive programmes in an attempt to end substance misuse among their service users (Sosin and Grossman 2003; Carr 2006). They are resource intensive, specialised and tend, because of the costs involved, to only be present within cities with significant substance misuse and homelessness problems. Within the evidence base, the great majority of evaluations of these services are American.

Evidence of effectiveness

3.68 The available US research evidence indicates that this form of service tends to have limited success. The essential problem, identified repeatedly in the evidence base, is one of ensuring compliance with treatment among homeless people who are not having their other

needs met. In the US, these services also run into difficulties because of the strict rules about abstinence and other aspects of behaviour they tend to try to impose on service users. These services tend to either fail to engage with service users at all, or to lose most of them prior to detoxification being completed (Weinberg and Koegel 1995; Weinberg 1996; Shinn and Tsemberis 1998; Tsemberis and Asmussen 1999; Tsemberis and Eisenberg 2000; Sosin and Grossman 2003; Sosin and Durkin 2007).

3.69 US research reports a very marked tendency for homeless people to miss first appointments, or to not attend subsequent appointments if they do attend on the first occasion. Orwin *et al* looked at 14 pilot stand-alone programmes in the US, which offered a combination of shorter and longer treatment and support programmes, and reported limited success:

> "In sum, all of the interventions lost two-thirds or more of their clients prior to completion and most lost considerably more. Residential interventions retained more clients than their non-residential counterparts, but highly intensive treatments typically retained fewer than less intensive" (Orwin, Garrison-Mogren et al. 1999, p.50).

3.70 Orwin *et al* concluded that various factors had produced this level of service failure:

- lack of motivation for abstinence, linked to there being no assistance offered for a host of other needs (not the least of which was housing), which Orwin *et al* also describe as homeless people 'not seeing value' in the service they were being offered;
- high demands being placed on service users, including total abstinence and, in the case of some residential treatment programmes, being expected to confine themselves to one building for 28 days;
- boredom, lack of privacy, lack of space, poor living conditions.

3.71 Sosin *et al* report on a US service model that offered some other assistance beyond detoxification, but which still focused primarily on detoxification and only offered other limited services in return for treatment compliance (Sosin, Bruni et al. 1995). Many strictures and conditions were placed on service users, as described by the research team:

> "Individuals are also required to progressively take responsibility for other activities needed to address their problems, such as obtaining employment, work training, or if neither is available, welfare benefits, attending the project's group and individual counselling concerning intrapersonal, relationship and permanent housing issues; and cooperation with a cognitive behavioural relapse prevention model…the clients also must remain abstinent from drugs and alcohol, and must sign a contract agreeing to cooperate with the (negotiated) treatment plan" (Sosin, Bruni et al. 1995, pp.2-3).

3.72 In this model compliance was not merely required with treatment, but with a wider range of rules about changing behaviour to 'counteract' homelessness. This model was contrasted with a supported housing service using an abstinence based approach in a randomised control trial. While it is important to note that Sosin *et al* do not portray the

results in this way, the results of these service experiments appear relatively poor, as homeless people essentially took flight from both these services. The treatment-only model lost eight out of ten service users prior to their completing treatment, the other service, which offered the supported housing, lost six out of ten (Sosin, Bruni et al. 1995). This was not a total failure, some homeless people were detoxified and moved into settled housing, but high delivery costs were coupled with quite poor results.

3.73 For some years, failures in this form of service provision were 'explained' by the assumption that this group was "difficult to engage" with. However, specific research suggests that homeless people with substance misuse problems tend to weigh costs and benefits when contacting these services in sophisticated ways. Harsh conditions, strict rules and an insistence on abstinence are balanced against limited potential gains, i.e. not receiving assistance with housing or other needs (Sosin and Grossman 2003). There was also the wider point that success rates for detoxification among people with a history of substance misuse who are not homeless also tend to be quite low (Mckeganey *et al*, 2004).

3.74 There is little evidence on such interventions in the rest of the World, and this may be because these models are particularly concentrated in the US.

3.75 In Scotland and the other UK countries there were small scale experiments with the development of open access medical services for people sleeping rough and hostel residents by the NHS. However, concerns were soon raised about continuity of care and the well-being of patients who were facing a range of risks to their health, because other needs were not being addressed (Fisher and Collins 1993; Hinton 1994; Hinton 1995; Pleace and Quilgars 1996; Power, French et al. 1999).

3.76 In recent years specialist medical services have tended to integrate with, or at least work increasingly closely with, social housing, voluntary sector services and social care (see below). It was never really the case that these services would attempt detoxification and many did not, for example, prescribe methadone, because there was felt to be insufficient support for homeless people the moment they left the clinic. A handful of these services had detoxification beds of their own (such as Great Chapel Street in London)[9], but most were dependent on referral to mainstream services[10].

3.77 Evaluations of stand-alone treatment services elsewhere have tended to be of schemes that had more in common with these UK approaches than they did with models used in the US. Attempts have been made to provide specialist medical services for homeless people with an alcohol dependency in Germany and Canada, for example (Fichter and Quadflieg 1999; Podymow, Turnbull et al. 2006) .

[9] See http://www.westminster-pct.nhs.uk/

[10] There are mainstream abstinence based services that homeless people can potentially access in Scotland. For example, the Lothians and Edinburgh Abstinence Programme (LEAP) is initiative funded for 2 years by the Scottish Executive and managed by NHS Lothian. The service is designed to promote and sustain abstinence. The programme is designed for 80 patients per year including any drug dependency including polydrug and alcohol. As a community rehabilitation service it will involve a holistic approach incorporating health and psychological needs, housing, training, employment, self-help and a spiritual purpose.

Suitability for Scotland

3.78 The understanding of substance misuse among homeless people in Scotland is considerable, it has long since moved beyond the point at which stand-alone clinics or residential services providing detoxification would be seen as a viable policy option.

3.79 These American services appear to have expected too much of homeless people with substance misuse problems, making support with substance misuse conditional on compliance with strict rules and not recognising other needs. These services also appear to have failed to recognise the complexity of substance misuse among homeless people, particularly the presence of multiple, interrelated needs (see Chapter 2). These flaws were evidenced in poor results, in which projects without any housing component were losing between seven or eight out of every ten homeless people they tried to engage with. It is important to note that these projects were not total failures, they did provide a route out of substance misuse for some homeless people, but they clearly failed to address the needs of the bulk of their target population.

Staircase, Continuum of Care and other transitional housing models

Description

3.80 Transitional housing for homeless people with a history of substance misuse are designed to equip someone for independent living. These services do not focus on substance misuse alone, they are also designed to promote readiness for living independently by addressing issues such as daily living or household management skills, and may also work towards promoting education, training and employment.

3.81 There are two forms of transitional housing. The first, which can be called single-site transitional housing, is more common in Scotland and other countries in the UK. The second is the staircase, or Continuum of Care model, which uses multiple stages of accommodation and services.

<u>Single-site transitional housing</u>

3.82 This approach uses a single, shared, residential setting with on-site staffing. These models are designed to take homeless people with substance misuse issues, from the street or from shelters or hostels, help address their substance misuse and guide them through a resettlement process. The entire process is often managed under one roof, though it is not uncommon for single-site transitional housing to incorporate some form of short term floating support to assist the process of actually moving into ordinary housing. These services may employ either a rehabilitation approach, which aims for sustainable abstinence or may adopt a harm reduction or harm minimisation approach.

3.83 Single-site transitional housing is often *generic,* focusing on substance misuse in general, rather than just on homeless people. However, there are examples of single-site specialist services that focus specifically on homeless people. Within Scotland and elsewhere in the UK, these services tend to be mainly for homeless people with alcohol misuse problems. Provision may either tolerate alcohol use or be 'dry'. Two providers of these services in Scotland are the Jericho house network and the Crossreach group.

3.84 The Jericho houses in Scotland are part of the services provided by the Jericho Benedictine Society. These 'dry' houses, which have around 10 residents each, are located in Dundee, Greenock and Paisley. They are specifically focused on homeless people with alcohol misuse problems and use the Alcoholics Anonymous peer support and 'buddy' system, which is centred on promoting and sustaining abstinence[11]. The services work towards abstinence rather than insisting upon it as soon as a service user arrives, but they do not tolerate on-site alcohol use.

3.85 The Crossreach Group runs Cunningham House in Edinburgh. This is a single-site transitional housing scheme that provides 23 rooms for men and women with substance misuse issues (both drugs and alcohol). The scheme requires abstinence and is designed to support that abstinence through a key-worker system. Alongside its focus on substance misuse, Cunningham House is also designed to support homeless people away from offending behaviour and to support people with mental health problems. The intention is that residents will move on to independent living. Crossreach also operates the similar Kirkhaven Project in Glasgow, which is designed to resettle homeless people with combined substance misuse and mental health problems[12].

3.86 As is noted above, these services do not operate in isolation but instead tend to be part of case management. Referrals to these services come from other service providers within their area of operation. Thus while these services are designed as 'all in one' single-site solutions, they are networked with other service providers and are dependent on those providers, for example in relation to securing access to suitable housing to allow people to move on.

3.87 Most transitional housing is intended for lone homeless people and some services cater for just one gender, usually men with alcohol misuse problems. There are examples of transitional housing for pregnant women and women with children who have drug problems in Scotland, but these forms of accommodation, for example those run by the Aberlour Child Care Trust, are not specifically focused on homelessness[13].

[11] http://www.jerichobenedictine.org/

[12] http://www.crossreach.org.uk/

[13] http://www.aberlour.org.uk/

Staircase and Continuum of Care models

3.88 This form of transitional housing is referred to as a 'staircase' approach in the EU (Sahlin 2005) and as the 'Continuum of Care' model in the United States (Ridgway and Zipple 1990). The exact form of the service varies between providers, but the basic logic is always the same. Individuals are taken from the street, shelters or other settings and then progress through a series of physically separate, distinct, residential services towards independent living.

3.89 In the US, the Continuum of Care model had its origins in community care for people with mental health problems or severe mental illness. Services were designed to gradually progress people with mental health problems towards independently living, by moving them from institutional settings into one or more stages of supported housing that grew progressively more like ordinary housing. However, there is not an in-built assumption that all service users will live independently, some may stop moving when they reach the most 'housing-like' setting that is deemed appropriate for their needs. Ridgeway and Zipple describe this process:

> In each setting on the continuum, the client is to become stabilized clinically and to learn specific skills. Once the client's level of functioning improves, or his or her need for services lessens, the client "graduates" and moves to a more normalized and less restrictive setting (Ridgway and Zipple 1990, p.12).

3.90 The Continuum of Care model for homeless people was designed specifically to follow this approach. The end of a Continuum of Care process may be residence in general needs housing *or* it can result in moving into permanent supported housing. Figure 3.2 shows the Continuum of Care model for homeless people employed in San Francisco. As can be seen, either living independently or in permanent supported housing could be the outcome of going through the continuum. The goal, however, is to maximise independent living.

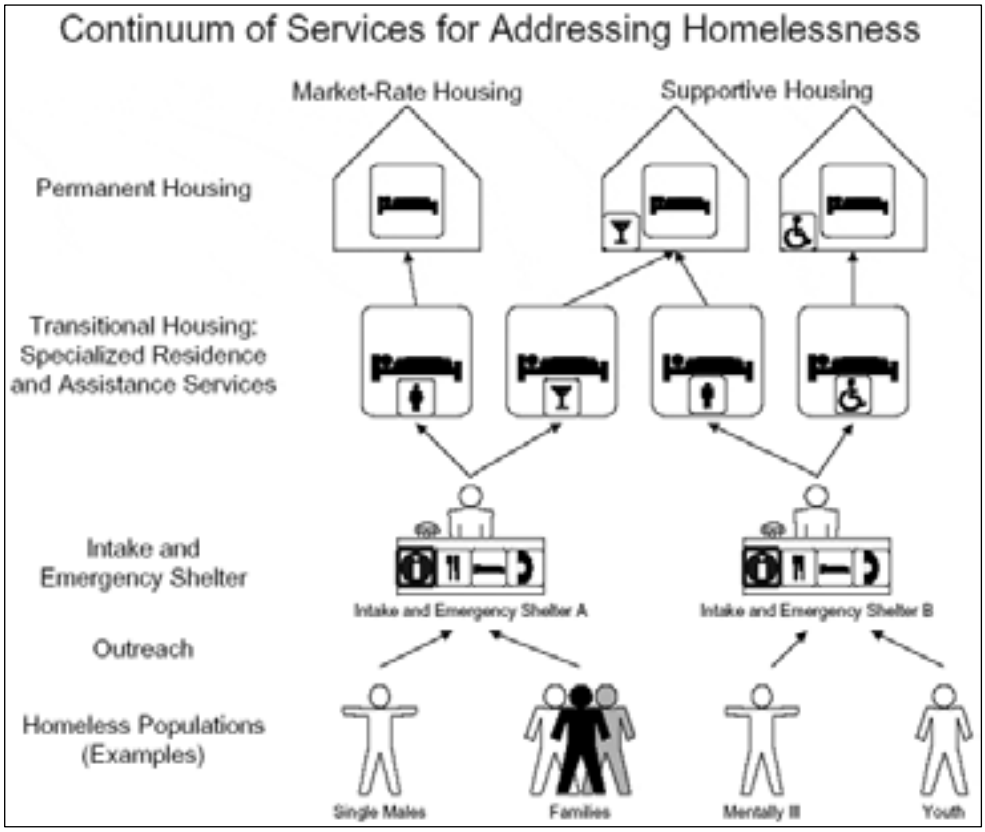


Figure 3.2: The San Francisco Continuum of Care Model for Homeless People (source: San Francisco Planning and Urban Research Foundation)[14]

3.91 Some Continuum of Care models in the US use detoxification coupled with key-worker support. Most employ a rehabilitation model using a range of supports, including group events, key-workers, peer support and other structured activities. These services require abstinence from their residents and can have very strict rules governing resident behaviour. Dordick describes the earlier stages of some Continuum of Care models as "quasi-militaristic" environments, in which daily life is highly structured with residents being expected to undertake tasks to promote abstinence and give them the skill sets to live independently, while being left with little time to themselves (Dordick 2002). As Dordick and others also note, progress through some Continuum of Care models is conditional on evidence of sustained abstinence, one is often sent back a stage, or ejected altogether, as a result of a relapse (Lyon-Callo 2000; Dordick 2002; Carr 2006).

3.92 Where possible, the continuum model is designed to promote independent living. In the American context, this means living independently in general needs housing, not being at risk of homelessness, not being involved in criminal activity, not being involved in substance misuse and being in sustainable paid work. This goal is broadly similar to those of policies designed to counteract social exclusion among people involved in substance misuse in Scotland and elsewhere in the UK.

[14] http://www.spur.org/

3.93 The staircase model is very similar to the American Continuum of Care. The model has its origins in Sweden, though as Sahlin notes, it is becoming more widespread in other EU countries (Sahlin 2005). Progress is made through a series of stages, commencing with shelters and then moving into 'category housing', which is a form of supported housing targeted on specific groups, which can include specialist provision focused on substance misuse. These services are based on a rehabilitation model.

3.94 Once these initial stages are complete, homeless people move into 'training flats', which are what the name suggests (sometimes called 'move-on' housing in the UK). Finally, homeless people are moved into 'transitional flats' which are general needs housing to which floating support is delivered, before they eventually live independently. As a homeless person "climbs up the staircase", there are improvements in physical standards, space, security of tenure and less monitoring of an individual by key-workers or support staff. There may be as many as five or six distinct phases of accommodation and support through which an individual passes prior to their being resettled.

3.95 These approaches are intended to be all-in-one solutions that attempt to deal with all homelessness using self-contained staircases of services. In the US, this is related to the wider environment, which is less service-rich than is the case in Scotland. These services have to be comprehensive, because there is not the same network of social housing, free healthcare, social care and voluntary sector services like that which exists across Scotland.

3.96 There are examples of comparable services in Scotland and the UK, but they are relatively unusual (McNaughton, 2004). Such services tend to be expensive, as is evidenced from the economic evaluations that have been conducted in the US (Devine, Brody et al. 1997) and their 'all-in-one' approach does not sit particularly well within the Scottish context, with its widespread emphasis on joint working.

Evidence of effectiveness

3.97 There is little hard evidence on the effectiveness of single-site transitional housing in Scotland or elsewhere in the UK. Successes are claimed by service providers, but these models tend not to have been subject to detailed evaluations and never to comparative longitudinal research using control groups.

3.98 These services are, nevertheless, often integral to responses to the needs of homeless people with substance misuse problems. The de facto practice in Scotland and the rest of the UK is that if needs and risks are pronounced, then placing someone in the community is less advisable than placing them in supported housing of some sort (Pleace and Quilgars 2003). If single-site transitional housing can bring someone to a point where they can be supported in the community, it has a clear role in wider joint working. Again, lack of systematic longitudinal evidence means it is not possible to determine how effectively these services complement wider joint working.

3.99 There is strong evidence from the US that services requiring abstinence from service users tend to be less successful at sustaining service user engagement (Bebout, Drake et al. 1997). If this pattern held true for Scotland, it would be the case that services based on

abstinence might prove less effective at sustaining contact with service users and could be more subject to abandonment by service users.

3.100 The Continuum of Care model is being subjected to sustained criticism in the US at the time of writing. These criticisms centre on evidence of its high attrition rate, by which is meant the rapid loss of service users between stages (Gulcur, Stefancic et al. 2003). Some reported that service users were abandoning Continuum of Care services because of requirements for abstinence (Dordick 2002; Acquire 2004; Carr 2006).

3.101 However, loss of service users did not seem solely linked to abstinence based approaches. A randomised control trial in Washington DC covering 158 homeless people from streets and shelters looked at a Continuum of Care model using a harm reduction approach. Although operating a tolerant regime, 60% of service users were lost, though 40% did sustain housing – a better rate than for some abstinence based models - over an 18 month period (Bebout, Drake et al. 1997).

3.102 Attempts were made to manage high rates of losses in the Continuum of Care model. The main mechanism was trying to ensure that only people suitable for a Continuum of Care programme would be picked by referral and assessment procedures. One study in New Orleans reported that only 9% of potential service users were selected for a Continuum of Care service to try to minimise loss of service users. Yet this approach was not successful, as only one third of these carefully selected clients actually completed the programme (Devine, Brody et al. 1997).

3.103 There was also some evidence that the Continuum of Care, a specialised and relatively expensive set of services, was not faring much better than placing people in ordinary housing with low level support. One longitudinal randomised control trial in Boston, covering 118 homeless people with both substance misuse and mental health problems, found that people in small, shared supported housing units fared better than those living in the community with low level key-worker support. Those in supported housing were less likely to experience homelessness, but the difference between them and those in ordinary apartments was not very great (20% compared to 35% experienced homelessness) (Goldfinger, Schutt et al. 1999).

3.104 The standard defence of the Continuum of Care model is that it is working with very hard to engage populations, focusing on people with substance misuse problems, who often have mental health problems. While a 20% or 30% success rate might not seem very high, once allowance was made for services working with alienated, chaotic people, with often challenging behaviour and high levels of need, it could be argued that it was questionable whether better results were achievable.

3.105 Unfortunately for the Continuum of Care model, a new form of service started to show better results. In contrast to this new form of support, called the Pathways Housing First model, Continuum of Care models appeared to perform less well. A prolonged longitudinal randomised control trial in New York suggested that 75% of Pathways users were housed at month 48, compared to 50% of Continuum of Care users (Padgett, Gulcur et al. 2006). The Pathways Housing First model is described in the next subsection of the report.

3.106 Tsemberis and Asmussen have identified five reasons why the Continuum of Care model was not producing better results (Tsemberis and Asmussen 1999):

- constant changes required to progress through continuum are stressful for clients, relationships in one setting are ended as they move further down/up the continuum;
- each change brings less staff support, which may not be suitable for people with dual diagnosis/multiple needs;
- skills learned for successful functioning in one stage may not be appropriate to subsequent stages;
- clients lack choice and freedom, there is an expectation on them to adapt to standardised levels of care;
- decisions about when and where people are moved are made by clinical staff, there is a lack of control and lack of privacy for clients.

3.107 The underlying logic of the Continuum of Care approach began to be questioned. The expectation that people could complete stages in set time, or according to set patterns, was increasingly being depicted as illogical, as Ridgway and Zipple note:

> "The course of psychiatric disorders, and of recovery and rehabilitation, are highly variable, nonlinear, and unique to each individual. Requiring a certain type of progress to occur in a certain time frame can spell failure" (Ridgway and Zipple 1990, p.12).

3.108 The Swedish 'staircase' model has been the subject of very similar criticisms. In one Swedish city, the extent of gridlock in a staircase service was such that it was estimated that it would take 34 years to re-house all the individuals living within it (Sahlin 2005). Another criticism is centred on what is seen by some researchers as a simplistic assumptions within some staircase models (see Chapter Two). Like most US continuum models, staircase models follow a rehabilitation model, viewing homelessness as linked to individual addictive behaviour, which when addressed, will tackle the root cause of their homelessness. Writing about the use of the model in Sweden and the EU, Sahlin comments:

> "Homelessness is no longer framed as a problem of shortage or ineffective allocation of housing, but as one of the excluded individuals' deficient qualification. This idea is promoted, shaped, and sustained by the staircase of transition" (Sahlin 2005, p.118).

3.109 The same criticism has been made of the Continuum of Care model, which is seen by some academics as having too great a focus on individual 'progress' on the continuum, with too limited an understanding of the support needs of homeless people (Carr 2006). Dordick, writing about the Continuum of Care model, notes:

> "Each sees the residents of the program as "flawed" individuals whose addictions and homelessness are the product of problems of character or "psyche". Recovery as those at [service] see it, is a journey of personal improvement supported by a conducive group environment" (Dordick, 2000, p. 18).

3.110 The difficulty these authors have identified with the Continuum of Care model is not that the focus is entirely on the individual, but that it is on one aspect of the individual's

behaviour and need: their substance misuse. What Dorkin criticises in the US and what Sahlin criticises in Sweden is an assumption within many 'staircase' models that if substance misuse is ended, then that in itself can guarantee a route out of homelessness. What the research on causation indicates is that often complex and varied needs requires a package of different services to provide a sustainable route out of homelessness.

3.111 A specific goal for the Continuum model was to help people into paid work where possible. Some research has raised questions about whether or not low status and poorly paid work enhances social and economic inclusion and general well-being. One study noted that:

> "...if marginal employment is the only employment option available to homeless substances abusers, and they are dissatisfied by their lack of responsibility, compensation, and potential from this station, it cannot be expected to positively structure their time away from substance abuse" (Hartwell, 2000, p.123).

3.112 Just as questions have been raised about the feasibility of the objective for some versions of the Continuum to end substance misuse, so too have questions about the realism of securing access to paid work for service users (Rosenheck and Mares 2007).

Suitability for Scotland

3.113 It is not possible for the review to recommend consideration of Continuum of Care approaches for Scotland in the light of the current evidence base. It is important, as noted above, to understand that these models are not failures, they can and do report successes. Nevertheless, large scale abandonment by service users has been reported, linked to the 'abstinence' ethos of some of these models, but *also* to the inherent logic of the staircase models, since there is evidence that those using harm reduction approaches also have limited effectiveness. It is to be noted, however, that these models, while quite widely criticised, remain at the heart of provision for homeless people with substance misuse problem in the US and in parts of the EU at the time of writing.

3.114 The role of single-site transitional housing is open to more debate because there is a surprising lack of clear evidence. These schemes are well integrated into existing models of homelessness service provision across Scotland. The consensus across homelessness services throughout Scotland and the other UK countries is that it becomes difficult or impractical to support homeless people with substance misuse in the community when needs reach a certain point, or risks become unacceptable.

The Pathways Housing First model

Description

3.115 The Pathways Housing First model began operations in New York. The service was originally designed to minimise the risk of homelessness and other problems among people with a severe mental illness, though the model was extended to include homeless and potentially homeless people with both substance misuse and mental health problems. The model is primarily designed for high needs groups, i.e. for individuals with diagnosed psychiatric problems and with substance misuse issues that include addictive behaviour (Tsemberis and Asmussen 1999; Tsemberis and Eisenberg 2000; Gulcur, Stefancic et al. 2003; Tsemberis, Gulcur et al. 2004; McGray 2005; Tsemberis 2005; Padgett, Gulcur et al. 2006; Stefancic and Tsemberis 2007) .

3.116 American researchers had begun to find that homeless people with substance misuse and mental health problems had a strong preference to live in independent housing. However, there was also evidence that they could not always cope in that housing on their own (Schutt and Goldfinger 1996; Schutt and Goldfinger 1998). However, relative failure in Continuum of Care models was associated with a lack of choice and control, part of which was being in a shared environment. (Tsemberis and Asmussen 1999; Dordick 2002). This suggested that while expecting people to live independently with little support was impractical, shared supported housing was not the right option either, some alternative approach had to be found.

3.117 During the 1980s what Ridgway and Zipple call a 'paradigm shift' was occurring in mental health services in the US. Continuum of Care models, which had originated in this field, were being replaced by what would become known as "Housing First" models. They noted that:

> "The primary conceptual element of the paradigm shift is the emphasis on the general need for housing among the population who are disabled by mental illness, as well as a critical need for housing for those who are homeless" (Ridgway and Zipple 1990, p.16).

3.118 Ridgway and Zipple also noted that a key difference was a "new emphasis on the development of normal housing options as a person's own home" (p.17). If somewhere was to be a home, there had to be an element of choice about what it was and where it was.

3.119 Continuum models had experienced relative failures because support needs were anticipated in 'training' stages that were intended as a staircase to independent living, whereas the new Housing First approaches enabled people to chose ordinary housing and could tailor then support to meet their actual needs. Choice was also extended to include support services, including an option *not* to receive support if one chose not to (Ridgway and Zipple 1990). Ridgway and Zipple summarised the broad differences between continuum and Housing First models in a table (Table 3.1):

Table 3.1: The shift from the Continuum of Care model to "Housing First" in the United States

"Housing First" models	"Continuum of Care" models
Own home	Shared and institutional settings
Choice	Placement
Normal role as citizen in community	Role as client of service
Control over services received	Staff control over services
Social integration in society	Segregated with others with shared need
Supported to live independently in situ	Generic training for independent living
Bespoke service package	Standardised service package
Long term support	Expectation of total independence

Adapted from Ridgway and Zipple (1990)

3.120 An important experiment took place in New York, using a sustained longitudinal evaluation that compared a Pathways Housing First model with a continuum model. The New York pilot was primarily intended for homeless people with severe mental illness, but due to the characteristics of this group, the Housing First service inevitably dealt with many substance misuse issues. To access the service, service users had to have "active symptoms or a history of a psychiatric disability that compromises their ability to function" (Tsemberis and Asmussen 1999). A history of violence did not disqualify potential service users from the Housing First programme. Forty-seven per cent of the service users reported having been arrested.

3.121 The key features of the pilot were:

- immediate provision of general needs housing which is not conditional on compliance with support and treatment services;
- service user control over where they lived (within the affordable options);
- intensive floating support being made available to service users, providing help with substance misuse, but also with housing issues, employment, education, physical health and general wellbeing and emotional and practical support;
- service user control over whether or not they used some services, including specific help in relation to substance misuse;
- no requirement for abstinence and a focus on harm reduction in relation to substance misuse.

3.122 Housing is secured for the service users as quickly as possible and is not conditional on compliance with substance misuse or mental health services, indeed a service user can refuse these services without there being *any consequence* for their housing. The housing is all in the private rented sector, the Housing First scheme having access to Federal subsidies that meet most of the cost of the rent. Within the constraints of what is affordable, service users were given options about where they wished to live.

3.123 Intensive floating support is made available via Assertive Community Treatment (ACT) teams, which are composed of a social worker, substance abuse counsellor, a nurse, a psychiatrist, a peer counsellor (i.e. an ex-homeless person with similar experiences) and an employment worker. There is also support for those service users to try to reconnect with

families, which in the UK would be called family mediation. Within New York, at the time of writing, there are seven teams, each supporting approximately 70 individuals, a total caseload of some 490 persons and households[15]. The range of services provided by the ACT teams is described as including:

- Psychiatric treatment;
- Individual and group substance abuse treatment;
- Daily living skills training;
- Budgeting and money management skills
- Advocacy for benefits and entitlements including Social Security, Medicaid, and Food Stamps;
- Health, wellness and recreational activities;
- Supports for family reconnections;
- Vocational and supported employment services; and
- Providing opportunities for artistic expression and socialisation through art, photography and writing workshops[16].

3.124 These ACT teams represent what is perhaps best understood as a welfare state in miniature. They are available on a constant basis, by which is meant 24-hour cover, seven days a week. Nearly the entire package of services is contained with Housing First's own Assertive Community Teams. Each individual is allocated a "service coordinator" who plays the role of bringing together the appropriate services from within the Housing First teams. When outside help is needed, this is sought by the service coordinator.

3.125 During the first year of their tenancy, service users must be willing to meet the service coordinator twice a month. There is no requirement to enter in either psychiatric or substance misuse treatment, they can refuse both, with no impact on their housing.

3.126 Services are open-ended and can be extensive. It is quite possible for the model to provide extensive services over many years to an individual. Services are withdrawn only when, and if, an individual starts to become more independent. However, there is *no expectation* that the individual will eventually live independently, the service will simply go on for as long as needed, which could be the rest of an individual's life. There is no 'staircase' to climb, no 'continuum' to progress along, the service user is put in the community, in ordinary housing and given considerable control over the floating support they can choose to use to maintain that position. The same logic is attached to substance misuse, a harm reduction model approach is used and there is no requirement that substance misuse cease.

3.127 Some Continuum of Care models do not require that individuals had to live independently, i.e. they can stop moving along the continuum once they reached a point beyond which they cannot progress, which can mean a life in shared supported housing. By

[15] Source: http://www.pathwaystohousing.org/

[16] Source: http://www.pathwaystohousing.org/

contrast, Pathways Housing First appeared to offer much greater control and independence because individuals went straight into their own home, there was also no pressure to move between settings, no expectation that someone should try to "climb the staircase" towards independence.

3.128 The control over services offered by Pathways Housing First to service users is not absolute. There is the requirement to have meetings with the service coordinator twice a month and, more significantly, a requirement to participate in 'money management'. This arrangement gives the Housing First service control over the finances of each service user, ensuring that the 30% of income is used towards rent (the requirement for Federal housing subsidies) and that crucial bills, including food and utilities, are paid[17]. While it is commonplace for Housing Benefit to be paid direct to a landlord rather than to a tenant across Scotland, the equivalent level of control over all of an individual's finances is usually only employed in cases in which someone has been legally determined as financially incompetent. The service is restricted only to those whose mental health problems are sufficient to enable them to access sufficient benefits, as many groups have little or no entitlement to benefit payments.

3.129 The recruitment of staff for Housing First focuses heavily on the selection of people who can understand the experience of substance misuse and mental health problems and homelessness. In 1999, one half of the project staff were described as formerly homeless and in recovery from substance misuse and mental health problems. The use of so many people with direct experience as staff is again unique to this service model. Tsemberis and Asmusson note:

> Staff must be capable of understanding the need to attend to the spoken and unspoken needs of tenants. They must be able to separate societal and personal beliefs concerning mental illness and learn to listen to the needs of the individual with whom they are working. It is essential that the tenant be allowed to make his or her own mistakes...The harm reduction philosophy is one of the more controversial programme practices and it is important for all staff to embrace this approach if it is to succeed. The [Housing First] harm reduction model offers an effective alternative to the prevailing 12-step programme approach which may create problems for those individuals who are accustomed to enforcing strict behaviour rules and sobriety compliance...the tenant who is actively using drugs or alcohol is offered a series of harm reduction objectives to reduce the harm that drug use causes in a manner that is supportive and empowering (Tsemberis and Asmussen 1999, p.123).

3.130 The Pathways Housing First model is distinct from current Scottish and British models in some respects. The relative intensity of floating support using a dedicated in-house interdisciplinary team and the support of people with high and complex needs in general needs housing can be found in Scotland. However, the open-ended commitment to support and no requirement or expectation that an individual must become more independent over

[17] Source: http://www.pathwaystohousing.org/

time is not commonly found in Scotland. The high use of formerly homeless people as project workers also differs from most current practice in Scotland.

3.131 There is no particular barrier to the Pathways Housing First model being used by households containing children as well as lone homeless people. However, social work involvement would be required to ensure any child protection issues were properly managed. The bulk of service users in the US are lone homeless people with substance misuse and mental health problems.

3.132 A wide range of services following some, though not *all*, of the operational principles of the Pathways Housing First model, are operating in the US as what are referred to as 'Housing First' services. In part, this is a reaction to Federal funding for 'Housing First' services being available, which has led to some rechristening and reorientation of existing services. Some of these services do not use ordinary housing but instead accommodate individuals in dedicated blocks, which produces a marked difference in emphasis, as they are in effect permanent supported housing, rather than something that could be seen as resettlement or tenancy sustainment (Pearson, Locke et al. 2007). The 'Housing First' label should not be read as indicating that a service is operationally identical to the Pathways Housing First model, as it conceals significant variation.

Evidence of effectiveness

3.133 As noted above, the Pathways Housing First model began to win attention as a viable alternative to the Continuum of Care in the US on the basis of a single, large longitudinal study being conducted in New York. This randomised control study monitored a sample of 225 people with substance misuse and mental health problems over five years, dividing the group between those using Continuum of Care services and Housing First services.

3.134 In 2003, reporting on the first two years of the longitudinal study, Gulcur *et al* reported that 47% of the group in Continuum of Care provision were still in contact with those services, compared to 88% of those in the Pathways Housing First service. Housing First also appeared to be delivering this high retention of service users at a lower cost than the Continuum of Care (Gulcur, Stefancic et al. 2003; Jensen 2005).

3.135 There was still evidence that Pathways Housing First was outperforming the Continuum of Care model at a lower cost level two years later. Reporting on the fourth year of the longitudinal randomised control trial in New York, Padgett *et al* reported that 48% of the Continuum of Care sample remained housed, compared to 75% of the Pathways Housing First sample. The slightly higher percentage for the Continuum of Care sample was explained by the loss of some respondents compared to year two (sample size was 87% of what it had been at the beginning), though this was not interpreted as introducing any bias (Padgett, Gulcur et al. 2006).

3.136 However, Padgett *et al* also found that the evidence relating to substance misuse was more mixed. While there was a small, but statistically non-significant, tendency for Pathways Housing First service users to be drinking less, there was no difference in the rate at which they were using drugs compared to Continuum of Care residents.

3.137 These findings were nevertheless seen as positive by the research team. They argued that any presumption that homeless people with mental health problems had to be entirely 'clean and sober' to maintain independent living had been overcome by Pathways Housing First. Further, Pathways Housing First also appeared to enhance housing stability very significantly (Padgett, Gulcur et al. 2006).

3.138 Pathways Housing First was also portrayed as having significantly lower costs. On a cost per-person-per-year basis Pathways Housing First was estimated as costing only 45% of an equivalent Continuum of Care place, 26% of the cost of keeping someone in prison and 13% of the cost of a State of New York psychiatric bed. To set this in some kind of context, the costs per-person-per-year were reported as $22,000 in 2004 and $22,500 in 2005, equivalent to about £11,000, at the exchange rates of that period. There was distinct possibility of individuals being in one of the other settings if they were not in a Pathways Housing First programme. One third had been in psychiatric wards prior to joining the programme, 54% had a diagnosed psychotic disorder, 90% had current substance misuse and 47% had been arrested at least once (Tsemberis and Asmussen 1999; Padgett, Gulcur et al. 2006).

3.139 Pathways Housing First was also providing sustained exits from long-term homelessness. One fifth of the sample had become homeless for the first time before they were 18, most had become homeless before they were 30, though they were on average 42 when they first entered the Housing First service. On average, they had spent 4.4 years homeless, by which in the US is meant time on the street or in shelters, prior to joining Pathways Housing First (Padgett, Gulcur et al. 2006).

3.140 The model is not without its critics in the US. Two other systematic studies conducted by Bebout *et al* in Washington and by Goldfinger *et al* in Boston, were attempts to critically assess the Housing First model. Both studies compared Continuum of Care models with ordinary housing to which much lower levels of floating support than those offered by Housing First were being delivered. Both found that continuum models fared little better than low intensity support in ordinary housing, either in terms of addressing substance misuse or sustaining exits from homelessness. Instead of providing ammunition against Pathways Housing First, this research showed that a significantly cut-down version of Pathways Housing First, offering a much lower levels of services, tended to perform no worse than Continuum of Care models (Bebout 1999; Goldfinger, Schutt et al. 1999).

3.141 Defences of the Continuum of Care model became more circumspect, Bebout *et al* arguing that their results should be taken as:

> ...a cautionary note about the abandonment of the continuum model in favour of the supported housing [Housing First] approach. Our data indicate that persons with dual diagnosis have phase-specific needs that may be best met through structured and supervised living arrangements (Bebout et al. p.940).

3.142 Such defences of the Continuum of Care model seem reasonable when the evidence base is considered. These services can produce good outcomes for some service users and it must not be forgotten that it does meet with some success in promoting and sustaining independent living. As noted above, many Continuum of Care services are operating in the US. What seems clear, however, which is a position that Bebout *et al* adopt, is that the

continuum is now increasingly viewed as just one service option, and that provision should also include Pathways or other Housing First models.

3.143 Recent national level research funded by the US department of Housing and Urban Development (HUD) looked at three types of Housing First services. The three services were defined as being 'Housing First' according to the following criteria:

- The direct, or nearly direct, placement of targeted homeless people into permanent housing. Even though the initial housing placement may be transitional in nature, the program commits to ensuring that the client is housed permanently.
- While supportive services may be offered and made readily available, the program does not require participation in these services to remain in the housing.
- The use of assertive outreach to engage and offer housing to homeless people with mental illness who are reluctant to enter shelters or engage in services. Once in housing, a low demand approach accommodates client alcohol and substance use, so that "relapse" will not result in the client losing housing.
- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods (Pearson, Locke et al. 2007, p. 2).

3.144 When the researchers began looking for case studies, they found 23 programmes across the US that were referring to themselves as 'Housing First', but which, according to the authors could be only be "classified in varying degrees as Housing First", with only nine programmes fully meeting the criteria shown above (Pearson, Locke et al. 2007, p. 10). In part, this seems to be a reaction to 'Housing First' being a term that has currency in the US, whereas the 'Continuum' label is seen as outdated. The researchers also found Housing First services that were working with homeless families and with groups of homeless people other than those characterised by severe mental illness and substance misuse problems.

3.145 The projects evaluated were the DESC (Downtown Emergency Service Center (sic)) in Seattle, a service that used 360 permanent flats in four blocks that it owned or controlled as accommodation, the Pathways scheme in New York which has already been described above, and the Reaching out and Engaging to Achieve Consumer Health (REACH) project in San Diego. This research concluded that:

> "The HUD priorities of addressing chronic homelessness and providing permanent housing are furthered by Housing First programs—The programs predominantly serve people who meet HUD's definition of chronic homelessness and achieve substantial housing stability for this population, although the most impaired clients, including persons coming directly from the streets, are still the most likely to leave" (Pearson, Locke et al. 2007, p.xxvi).

3.146 This research found that these models were more effective than the Continuum of Care, but also reported that a number of conditions were necessary to ensure that these 'Housing First' services could deliver good performance:

- success was conditional on access to a substantial supply of suitable affordable housing;
- when the housing preferences of service users were met, housing stability tended to improve;
- flexible and comprehensive 24-hour support that could assist with mental health problems, daily living skills, substance misuse and housing issues was required, the more flexible and comprehensive this was, the better;
- the importance of 'client-driven' (choice based) care and support programmes;
- long term commitments were needed, there was little evidence of improvements in substance misuse or mental health problems in the year-long longitudinal study;
- there was still some loss of homeless people with the most extreme forms of need, including some street homeless people, although less so than for other types of services.

3.147 The HUD funded research recommends Housing First models while at the same time conceding that its results will not be immediate or dramatic. The authors note:

> "While the housing provided by the programs increased housing stability and afforded the opportunity to receive treatment, substantial progress toward recovery and self-sufficiency often takes years and is not a linear process" (Pearson, Locke et al. 2007, p.102).

3.148 However, the HUD research was also comparing three 'Housing First' programmes that used quite different organisation and methods of service delivery from one another. The REACH programme was quite often using a two-tier approach, placing people in ordinary housing after stays in supported housing, whereas the DESC project was effectively providing what, in Scotland, would be described as permanent supported housing. Only the Pathways model was routinely using outreach to ordinary housing as its basic form of service delivery. All the projects, however, followed the same ethos and tolerance of substance misuse as Pathways and did not make access to accommodation conditional on abstinence or service use.

3.149 There is an important difference between the recommendations of the US government funded HUD research and those of the academic papers focused on the Pathways Housing First model in New York. The government funded research talks of slow and mixed progress towards a clear goal of independent living, an end to substance misuse and paid work (Pearson, Locke et al. 2007). This is distinct from the goal of Pathways Housing First as reported by academics, which was to achieve independent living and an end to substance misuse where possible, but not to either expect or require it (Tsemberis 2005).

3.150 This is illustrative of a political concern with funding services that do not promise individual 'improvement' in all cases. In future years, it may be that Federal expectation of abstinence and independent living as an outcome for most service users will generate friction with Housing First models that are not designed on this assumption, the Pathways model being an obvious example. These Housing First models might fall out of favour, if they

cannot generate concrete reductions in substance misuse, even if they can manage to keep more of its users in stable housing and within reach of services.

3.151 There is also evidence of the re-labelling of Continuum-like service models as 'Housing First' in the US. For example, a project called the Denver Housing First Collaborative describes itself as prioritising housing, but assesses individuals as either 'housing ready', which is defined as 'ready to access treatment,' or as 'requiring treatment' prior to housing, which has strong echoes of the Continuum of Care approach. The Denver service makes no mention of service users being offered choices, nor of tolerance of continued substance misuse. However, the project's use of assertive community treatment teams, coupled with either housing in the community, or shared supported housing, has been reported as far more cost effective than previous 'treatment only' services (Perlman and Parvensky, 2006).

3.152 The evidence suggests that the management of risk, i.e. that an individual will not cause harm to themselves or others, by Pathways Housing First and other Housing First models is acceptable. However, the issue of risk and risk management is not fully addressed by the current evidence base.

3.153 European research has reached conclusions that support the ethos, if not the actual practice, of Pathways Housing First. In a review encompassing research on resettlement of homeless people with support needs in Dublin, Milan and Hanover, Busch-Geertsema concludes that placing homeless people into ordinary housing is, in and of itself, a socially inclusive act. Like the advocates of Pathways Housing First, Busch-Geertsema also concludes that expectations that homeless people with support needs can eventually live independently and secure employment may not be realistic, arguing that services that expect too much of homeless people in these groups are more likely to exhibit failure (Busch-Geertsema 2005).

3.154 There are many services with significant similarities to Pathways Housing First in Scotland. Many Supporting People services providing floating support are offering broadly similar support. While there is the tendency to use joint working to meet needs through packages of support, rather than the near 'all-in-one' approach used by Pathways Housing First, more intensive services based around extensive contact with one key worker do also exist. Support may quite often, though not always, be time-limited in Scotland and there is likely to be less emphasis on service user choice and the use of former service users as project workers. Support may also sometimes, though not always, be less intensive than that offered by Pathways Housing First. Harm reduction and harm minimisation are accepted operational norms in Scotland and in other UK countries, whereas this is not the case in the US. There is a key difference in the use of the private rented sector by the Pathways Housing First, whereas most Scottish services would be mainly or entirely using the social rented sector, but this is a function of Pathways having no social rented sector it can use.

3.155 Pathways Housing First is not "revolutionary" by Scottish standards. It can be compared to a service like the intensive outreach services offered to vulnerable people at risk of homelessness by the Glasgow Simon Community (Quilgars and Pleace, forthcoming) or to the NEST project in South Lanarkshire Council, which supported 20 families with substance misuse problems between 2004 and 2007 using outreach to prevent homelessness and enhancing life chances (Paton, 2007). In the Scottish context, Pathways Housing First, while still incorporating innovative approaches like the use of many former service users as

workers and providing an open ended, largely choice-based 'all-in-one' service, looks less radical than it does in the US context.

Suitability for Scotland

3.156 There is a fundamental difference in emphasis that the homelessness legislation has created in Scotland in comparison to the US. In Scotland, the response to homelessness has primarily involved the State *providing housing* to homeless people and in this sense, all responses to homelessness over the past 30 years are 'housing first'.

3.157 It is perhaps helpful to think of Pathways Housing First coming from an American realisation, over time, that 'treatment only' or 'support only' responses were not working because of a lack of attention being paid to sorting out the most basic of needs, a settled and suitable place in which to live. By contrast, Scotland's services reached a similar conclusion from the other direction. While it would be inaccurate to describe approaches in Scotland as being entirely 'housing only', failures around sustaining tenancies for vulnerable groups like people with a history of substance misuse can be attributed to service responses being 'housing led', the problem was found to be a lack of emphasis on support (Pleace, 1995), which eventually led to *Supporting People*, whereas the 'American problem' was a lack of emphasis on housing.

3.158 Pathways Housing First does not represent a quantum leap compared to existing multi-agency joint working responses in Scotland. However, there are potentially useful lessons about the effectiveness of a user led, choice-orientated and comprehensive support services in sustaining highly vulnerable homeless people in settled tenancies.

3.159 Pathways Housing First is in effect an argument that full independence and economic inclusion is not a realistic option at all times and for all groups in society. It is designed on the basis that substance misuse and mental health problems can be successfully managed for the benefit of formerly, and potentially, homeless people, but not necessarily overcome in all instances.

3.160 Pathways Housing First is a specific service for a high needs group, being originally intended for homeless people with severe mental illness and still catering for that group who also tend to have high rates of substance misuse. The attractions of the model lie in the better quality of life for service users it appears to offer over some supported housing and in more sustainable housing outcomes. The model may be a more attractive and economic prospect than the use of permanent supported housing and some transitional supported housing models, though a properly evaluated pilot within Scotland would need to be conducted before the model was adopted. Again it needs to be borne in mind that the goals of the model are more limited than those for other American services and in some senses this 'explains' elements of its success. The Continuum of Care models are trying to end substance misuse, risks of homelessness and promote independent living, something harder to achieve than the housing stability and harm reduction goals of Housing First.

3.161 Whether the model is adopted in Scotland ultimately rests on whether the underlying logic of Pathways Housing First, that compromises have to be made in terms of what is expected of many homeless people with a history of substance misuse, is seen as a logical

one. However, current practice in Scotland, for example in the Glasgow Hostel Closure Programme, which uses long term supported housing for those former hostel residents who are deemed too frail or vulnerable to live in ordinary housing, already tends towards following this basic idea in any case.

3.162 One potential difficulty with using dispersed general needs housing, even when there is 24 hour staff cover, lies in the management of risks that someone may present to themselves or to those around them. These issues are easier to manage in a staffed environment with all the residents on site, and, although this is complicated by what people may do once they leave the building, it is less complex than monitoring risk in dispersed housing over a large area, particularly if entry and exits are controlled or monitored. This does suggest a role for shared, staffed supported housing for some service users, where risk management is a particular consideration. The US research is not entirely clear on the success of risk management in Housing First, or the criteria on which some individuals or households might be excluded (there is no automatic exclusion if someone has a history of violence, though violence towards staff is not tolerated).

3.163 Care is needed with respect to the terminology of 'Housing First'. There are specific programmes like the Pathways model that follow a user-led, harm reduction approach. However, not all the programmes or services referred to as Housing First follow these same ideas and can be closer to Continuum or staircase models in their day to day operation. If a 'Housing First' approach is used in Scotland, it needs to be very clearly established what is being referred to.

Permanent supported housing

Description

3.164 Permanent supported housing for homeless people with a history of substance misuse is quite unusual. It is more common in the US than in Scotland or in other UK countries, but is also relatively unusual there. All schemes take the form of shared, supported housing, in which residents either have self-contained studio flats, bedsits or rooms (which in more recent examples will be en-suite).

3.165 There is not a significant literature or evidence base on this form of provision in the UK, US or Europe. This seems to be related to it being an uncommon form of service provision.

3.166 Examples in Scotland include Buchannan Lodge, which is run by the Talbot Association in Glasgow. The service is a "wet" hostel that operates a harm reduction regime for homeless people with a history of alcohol misuse. The project has a role in taking in men aged over 50 who have been re-housed due to the city's closure of its large, long-stay homeless hostels. It is a personal care and health service, as much as a housing service, and is intended for permanent residence[18].

[18] http://www.talbotassociation.com/

3.167 St Mungo's, the London based voluntary sector organisation which has been focusing on rough sleeping for many years operates what it refers to as "High Support" projects. These include care homes which tolerate alcohol use as part of a harm reduction based approach[19].

3.168 No supported housing service in Britain tolerates illegal drug use, though some will allow use of prescribed methadone for heroin addicts, albeit under supervision. Some services provide sharps bins and needle exchange, as part of the general emphasis on harm minimisation and harm reduction that has arisen out of a concern about HIV and other blood borne infections.

3.169 North American permanent supported housing also does not tolerate illegal drug use. There are however, examples of "wet" supported housing (Podymow, Turnbull et al. 2006).

3.170 Where these services exist within Scotland, they tend to be part of joint working network and will receive referrals from other agencies. As is the case in relation to single-site transitional housing, these services will be employed when the risks of supporting someone in the community are judged to be too high, a good example being the use of permanent supported housing in the Glasgow Hostels closure programme (Glasgow Homeless Partnership 2002; Glasgow Homelessness Network 2003) .

Evidence of effectiveness

3.171 There is not a significant evidence base relating to permanent supported housing for homeless people with a history of substance misuse in the UK. It is not clear how successful these services are at harm reduction in substance misuse or in sustaining exits from homelessness. As these services are designed for groups of formerly homeless people who will not move on into independent living, monitoring their service outcomes over time should be unproblematic and would be a useful exercise.

3.172 In the US, evidence suggests that these services are not particularly successful when they require abstinence from their users. One longitudinal study in New York found that abstinence-based permanent supported housing was no better at preventing recurrent homelessness than general needs housing with low-level floating support (Lipton, Siegel et al. 2000). Some models calling themselves 'Housing First' are in effect providing permanent supported housing, an example is the DESC project in Seattle (Pearson, Locke et al. 2007).

3.173 Again, drawing on the US evidence, Housing First interventions, which can in effect be 'permanent' because they are open ended, may provide a more cost effective and successful alternative to some forms of permanent supported housing (Jensen 2005).

[19] http://www.mungos.org/

Suitability for Scotland

3.174 Evidence on permanent supported housing for homeless people with a history of substance misuse is limited. It may be the case that this form of provision is useful when the needs of an individual, or the risks they present to themselves or to others, reach levels that cannot be managed cost-effectively in the community. Some individuals may also prefer to live in a group environment, particularly if they are likely to be isolated in the community.

3.175 Housing First models may provide a lower cost alternative to developing and operating permanent supported housing. However, such services would need to be piloted within Scotland to determine if they had better outcomes, including a better quality of life for service users and to determine if they were more economic.

Preventative services

Description

3.176 There is little in the evidence base about services intended for the prevention of homelessness among people with a history of substance misuse. The lack of a tie-in between homelessness prevention and substance misuse services, particularly in relation to drugs misuse, has been criticised at EU level (Doherty and Stuttaford 2007).

3.177 The difficulty, as was outlined in Chapter Two, is that the associations between substance misuse and homelessness are complex. Homelessness and substance misuse are undoubtedly associated, particularly among lone homeless men in shelters, temporary hostels and living on the street, but the association is not a simple one. There is also the strong evidence that substance misuse is rarely the sole issue or need found among homeless people with a history of using drugs and/or alcohol.

3.178 In many respects, a prevention service that focuses just on substance misuse makes little sense in the light of the current evidence base. It is known that the problem of homelessness is complex, and, while substance misuse may be an issue, it is unlikely to be the sole issue (Neale 2001). Thus preventative interventions must be multifaceted and multidisciplinary, as concerned with the issues of housing need, isolation, lack of economic engagement, poor education, limited social and daily living skills, physical and mental health problems as they are with substance misuse.

3.179 Scottish Executive's Homelessness Task Force identified a number of groups at high risk of homelessness and advocated that local authority homelessness strategies give specific consideration to prevention activities in relation to these groups[20]. These groups were as follows:

[20] Scottish Executive Homelessness Task Force (2002) *Helping Homeless People: an action plan for prevention and effective response* http://www.scotland.gov.uk/library5/housing/htff.pdf

- Tenants threatened with eviction
- Care leavers
- Ex-offenders
- Former armed forces personnel
- Asylum seekers granted leave to remain.

3.180 The absence of substance misuse is perhaps a little surprising. While most people involved in substance misuse do not become homeless, neither do most of the people in the groups listed above. Indeed, there is less clear association with being in the services and experiencing homelessness (Johnsen, Jones et al. 2008) than there is between injecting heroin and experiencing homelessness (Kemp, Neale et al. 2006).

3.181 Preventative services within Scotland tend, as they are in England, to be generic, in that they are aimed at all or most potentially homeless people rather than specific populations[21]. They includes rent deposit schemes, housing advice, family reconciliation services (mainly for young people who have left home after disagreements) and various forms of debt counselling and financial management. For people with higher levels of need, preventative tenancy sustainment services, using floating support services or transitional housing, may be employed (Pawson 2007; Pawson, Davidson et al. 2007).

3.182 Recent evaluative research in Scotland looked at various examples of supported transitional housing for potentially homeless young people. These services provided single-site transitional housing for young people and sometimes included provision of meaningful activity (constructive, work related activity), alongside support with managing anti-social behaviour and support with housing needs. Help with substance misuse was usually confined to referral to external agencies and these schemes tended to have substance misuse policies that resulted in expulsion if they were broken (Pawson, Davidson et al. 2007). Substance misuse can be a factor in causing relationship breakdowns between young people and parents and a trigger for homelessness, there is some evidence that services that can provide assistance with substance misuse and also mediate between young people and parents can be effective at preventing youth homelessness, including among those aged under 16 (Quilgars et al. 2005).

3.183 In other areas, Glasgow and Fife being examples, substance misuse services are integrated into prevention strategies and can be used by individuals who are at risk of homelessness. In most instances, an individual must present as potentially homeless to reach the assessment and referral processes by which these services are accessed. This process is essentially the same as case management and joint working for homeless people with a history of substance misuse, except the interventions begin prior to homelessness having actually occurred. In most instances, however, services designed specifically for prevention are generic and any referrals for substance misuse issues tends to be to mainstream services.

[21] There is something of an exception to this in that more specialist services focused on preventing youth homelessness do exist (Pawson, 2007; Pawson, Davidson et al 2007).

3.184 In the US, higher intensity services, including Housing First and continuum models, are designed for both homeless and potentially homeless populations. Thus a Housing First scheme may take referrals from agencies working with homeless people on the street, hostels and night-shelters, but also from prisons, psychiatric hospitals and other services (Pearson, Locke et al. 2007). A distinction between 'homeless' and 'potentially homeless' is not really made.

3.185 European interventions tend to be focused on homeless populations. There is a concern to prevent recurrent homelessness and in this sense the interventions are preventative. Across most of the EU there is little evidence on services designed to prevent homelessness from occurring, although studies have been undertaken in England and Germany (Fitzpatrick and Stephens 2007) .

3.186 Most generic preventative services may be accessed by any group of potentially homeless people, including households containing children. Some more specialised services, such as transitional housing for young people, tend to focus on lone individuals, but others, such as tenancy sustainment, are in principle accessible to any household.

Evidence of effectiveness

3.187 The evidence on homelessness prevention services within Scotland is mixed. Some specific interventions, such as supported transitional housing for potentially homeless young people, have met with mixed levels of success. Writing in 2007, Pawson *et al's* evaluation of homelessness prevention in Scotland concluded that preventative services were still evolving and were often 'rather small' and 'experimental' in nature. Prevention services also tended not to be focused on substance misuse (Pawson, Davidson et al. 2007) .

3.188 The evidence on the effectiveness of the staircase and Continuum of Care models, which could work with potentially homeless people, has been explored in detail above. It is also possible that stand-alone treatment and support services focused on substance misuse could have a role in prevention. As described above, the evidence is most of these interventions have met with limited success, have fallen out of favour in the US, and are being replaced with Housing First (Pearson, Locke et al. 2007).

Suitability for Scotland

3.189 Homelessness and substance misuse are both destructive experiences, the more so when they occur together. Prevention of either experience, where possible, is clearly a desirable policy goal (see Chapter Two).

3.190 The available evidence is that homelessness associated with substance misuse has multiple potential causes and requires packages of services to alleviate and end it. The same holds true for homelessness prevention, in that a service just focused on substance misuse, even if specially designed for homeless people, will not be necessary or sufficient to prevent homelessness from occurring.

Summary

3.191 Providing resources are in place and there are no barriers to service interaction, joint working models that case manage homeless people in the community using multi-agency packages of care, the standard practice across Scotland, is widely seen as effective. However, there is more research and guidance on the barriers to joint working than there is systematic research on service outcomes. Services based on the management of substance misuse alone as a means to counteract homelessness tend to be unsuccessful. There is evidence, mainly from the US, that services that insist on abstinence also tend to have limited success. Within the US, there is a strong evidence base in favour of the use of the Pathways Housing First service, a form of multidimensional intensive floating support for homeless people with substance misuse and mental health problems that uses ordinary housing. However, Pathways Housing First models are intended only for high needs groups and while there is evidence that they promote housing stability, they are an open ended service that does not expect or guarantee an end to substance misuse. Some of the key elements within the Pathways model, such as the emphasis on securing settled accommodation, recognising the complexity of need, the use of harm reduction and providing multi-dimensional service responses, were mainstream practice in Scotland before the Pathways approach began to be piloted in the US.

4 Measuring service outcomes

Introduction

4.1 This chapter of the report is concerned with the effective measurement of service outcomes. The general principles of effective outcome measurement are discussed and the issues that may compromise accurate measurement are examined. Consideration is then given to the indicators that might be used to assess service outcomes, with reference to the draft indicators developed by the Homelessness and Substance Misuse Advisory Group (HSMAG), which are included as **Appendix 2** of this report. Reference is also made to an example set of outcome measures, derived from the results of the review, which are included as **Appendix 3** of this report. Readers should note that these examples are not intended as working sets of outcome measures, which would need to be very carefully agreed, tested and piloted. Instead these example outcome measures are intended as an *illustration* to aid discussion as to how outcomes might be measured. The example set of outcome measures Appendix 3 is also intended to help describe some of the problems that can arise in outcome measurement.

4.2 Within this chapter it is argued that outcome measurement has to allow for the variable, non-linear, nature of both substance misuse and homelessness and set *realistic* targets. It is also argued that only the longitudinal assessment of service outcomes can give a clear picture of service effectiveness.

Basic issues in outcome measurement

4.3 The key considerations in developing effective outcome measurement centre on ensuring that the system being employed is robust, simple to administer, can be applied consistently and uses realistic indicators that reflect sensible objectives for services. The key considerations in effective outcome measurement are:

- assessing the extent of 'programme fidelity' or 'model drift';
- assessing the extent of service 'evaluability';
- assessing whether or not generalised outcome measures are appropriate to a given service;
- the trustworthiness of data sources;
- allowing for context;
- assessing the extent to which any positive outcomes are sustained;
- practicality; and,
- realism.

4.4 It is common practice for pilots of services to modify their original design in response to operational realities. For example, a pilot project for homeless people with a history of substance misuse might be designed with an assumption that it can access community mental health services, but the operational reality might be that those services are under too much pressure. This could result in one of two modifications to its original design, it could either cease to cater for homeless people with substance misuse and mental health problems, or it could negotiate and lobby for its own specific mental health resource.

4.5 Another example is when a successful pilot programme is rolled out after a successful test. It is not uncommon for the operational reality of a service to differ from that of the pilot on which it was based. This can be for a host of reasons, two of the common ones are that the pilot was better resourced or that each organisation that adopts the pilot model 'tweaks' it slightly. Over time, variations in resources and minor alterations in design, mean that services that are nominally identical in operation actually begin to differ from one another significantly. This process can be observed currently in the US, in which projects that are all nominally 'Housing First', are beginning to diverge from one another significantly (Pearson, Locke et al. 2007).

4.6 Measuring 'programme fidelity', or 'model drift', simply refers to testing the extent to which a service reflects its original objectives and design. If programme fidelity is not monitored, one cannot be sure how far success or failure is due to the original design or due to the ways in which service providers or commissioners have modified that design. Even small changes to an original concept might lead to its failure or to its success.

4.7 Programme fidelity is usually assessed once a project has been operational for some time, as any changes that are made to day-to-day running will occur as a project beds down. It is also necessary to track whether any operational changes are occurring over time (Orwin 2000).

4.8 Another key consideration is whether or not a service has clear and realistic goals, what some Americans term as its 'evaluability' (Orwin, Sonnefeld et al. 1994; Orwin, Sonnefeld et al. 1998; Orwin 2000). On the one hand, stated objectives may be too broad and simplistic, for example, a project that states that its only objectives are to 'end substance misuse and homelessness'. Some American projects, as was discussed in Chapter Three, have set themselves broad and simple objectives of this sort, and as a consequence, their success rates can look very low. The reality may have been that these projects were having a wide range of smaller, but nevertheless positive, effects that were making a difference to the lives of service users, which were not recorded.

4.9 Projects may also have quite vaguely defined objectives that are ill-defined and difficult to measure. For example, if clear and specific aims are not in place, a project objective to 'improve self confidence', is actually fairly ill-defined from an outcomes measurement perspective. Developing self confidence is a laudable and logical aim, but there is a need to be specific about what *exactly* that means, because unless it is very clear, developing a meaningful measure of whether that outcome has been 'achieved' is problematic.

4.10 There is a danger in outcome measures that are too broad and simple in nature to record the positive impacts a service may have, or which are too vague to be assessed. In essence, bad project design is reflected in any attempt to monitor the outcomes of a service. As noted by Weiss, any sins in service design are visited upon the evaluation (Weiss 1973).

4.11 Useful guidance on these issues was produced by the former Effective Interventions Unit in Scotland. The guidance distinguishes between an 'aim', the overall result that a service is intended to achieve, the objectives, which are focused on specific results, which need to be measurable, achievable and realistic, and the overall rationale for a service, which is the underlying logic of an approach (Effective Interventions Unit 2001). Some American research also makes specific reference to the need to have a clear understanding of the logic model of a service, when assessing its outcomes (Orwin 2000).

4.12 A key consideration, related to both programme fidelity and the clarity of service objectives, is whether or not a service requires a specific indicator set to measure its outcomes effectively. Ideally, service commissioners want data on outcomes that they know are consistent across services, which allow them to both compare like-with-like, and to compare the performance of different types of service models against one another. This can be quite difficult to do for a number of reasons and while the gains attached to simple, generally applicable outcome measures can be very considerable, there can also be a downside to using one, fairly simple, set of outcome indicators.

4.13 In terms of measuring specific service outcomes, difficulties arise in using generic indicators the moment that intended project outcomes differ significantly. At a basic level, outcome comparison may seem very simple, i.e. does the project produce sustainable exits from homelessness, end substance misuse and so forth. However, projects for homeless people with a substance misuse problem may have very different goals, one may focus on resettlement or tenancy sustainment, another on developing emotional literacy and meaningful activity among its service users. One set of indicators may not suit all service types.

4.14 This can be coped with by not attempting to measure very specific projects or projects with hard-to-measure outcomes directly. For example, if young homeless people with substance misuse problems have attended an arts-based project and this can be directly associated with better outcomes in tenancy sustainment or family mediation than are found among comparable young people who did not attend such a project, then there is an indication that the project is effective. However, there is a need for caution in using broad associations to test service effectiveness, just because the potential for error increases when something is not being directly examined.

4.15 The other route is to develop separate sets of outcome measures for each service type. This makes cross-comparison of different types of services more complex. However, all approaches involve compromises and it is ultimately for service commissioners to decide where their priorities lay.

4.16 Another consideration is the trustworthiness of information. Clearly, self-reporting by services is fraught with danger of misrepresentation: the incentives to conceal mistakes, hide failures and over-represent success are obvious. Services may also attempt to 'cherry pick' individuals with whom they feel they have the best chance of success. It will often be the case that individual livelihoods and organisational viability will depend on successful outcomes being reported to the relevant commissioning or planning agency. The three ways in which to potentially counter this issue are random auditing and inspection, using an independent agency to monitor outcomes and employing multiple measures of effectiveness.

4.17 Random auditing and inspection is not entirely reliable, because it will only detect fraud and error on a haphazard basis. This also adds to the cost of outcome measurement.

4.18 The standard approach in the US is to employ a university to conduct a longitudinal randomised control trial. This is a luxury by Scottish, British and EU standards and is often too expensive to be contemplated, though it does offer a standard of proof that is not accessible by any other route. If one of these studies reports that something works, one can be much more confident that it does than when other evaluative methods are employed. As described in Chapter Three, the adoption of the Housing First model by Federal government in the US is in part a result of the longitudinal evaluation of the Pathways Housing First model in New York[22].

4.19 Multiple measures of effectiveness make it more difficult and complex to hide successes and failures, but they can have administrative costs. Asking the same question in different ways and then looking for inconsistency across the answers is a basic technique, but it makes the collection and processing of data more complex and time consuming. It is also possible to seek the same effect by seeking data from different sources, for example both service providers and service users. However, there is evidence from US research that service users and service providers recall and record things in different ways (Pollio, North et al. 2006).

4.20 The context in which a service is operating is very important to understanding its level of success or failure. Writing about the evaluation of homelessness services in the US, Orwin notes that services:

> "...do not function in isolation; rather, they function in the context of a network of services in a broader community. Such contextual factors play a potentially important role, since the effectiveness of an intervention cannot be isolated from the specific environmental context in which it was effective" (p.314) (Orwin 2000, p.314) .

4.21 An obvious example here is case management of homeless people with substance misuse problems via joint working. In a service rich environment in which there are few resource problems and access to specialist forms of support, it would be expected that such an approach would be successful. In an environment in which services were scarce or uncooperative, the same approach could fail (see Chapter Three). Services are rarely entirely self-contained and self-reliant, even models like Housing First cannot provide everything, and therefore cannot control everything themselves. As noted in Chapter Three, some US research shows that Housing First depends on affordable housing supply for success, something it cannot directly control (Pearson, Locke et al. 2007).

4.22 The role of context can be controlled for in two ways. First, one can ask services to report on contextual factors, but there are all the risks associated with self-reporting by those services, i.e. poor services could try to blame everything on other agencies or local conditions. Second, area-based indicators, which might be nationally collected data on levels of substance misuse and housing stress, for example, can be used to help contextualise services and their outcomes. Generally, care must be exercised that apparent successes and failures are looked at in a broader context.

4.23 Tracking service outcomes over time is difficult, but it is also the most rewarding form of outcome monitoring. Perhaps the most important question for service commissioners

[22] Source: http://www.pathwaystohousing.org

and service providers is whether or not positive outcomes are sustained over time. If service users who had apparently exited homelessness and/or ended their substance misuse are relapsing into addiction, or returning to homelessness, once they leave a service, then the resources involved in providing that service are not being well-used. Equally, any service that is provided on an ongoing basis, such as permanent supported housing, needs to demonstrate that there are durable positive outcomes for its service users.

4.24 There are three means to track service outcomes over time:

- dedicated longitudinal surveys;
- retrospective survey techniques;
- data merging and sharing.

4.25 There are now demonstrably successful longitudinal methodologies for sustaining contact with formerly homeless and substance misusing populations, developed both in Scotland and in the US (Wright, Allen et al. 1995; Kemp, Neale et al. 2006). These are most commonly employed in the US and tend to be large, relatively expensive, academic-led studies, a good example being the evaluation of Housing First in New York (Padgett, Gulcur et al. 2006) .

4.26 A key concern with this form of outcome monitoring is ensuring that the sample is not biased. Potential bias can arise because of what some American academics refer to as 'pre-inclusion attrition', which means that a sample is not representative because some groups of people were less likely to join it than others (Wright, Allen et al. 1995). The other concern is 'selective attrition', which refers to a longitudinal sample losing disproportionate numbers of specific groups of people over time. The concern is less with simple loss of numbers than with a loss of numbers that effects the overall representativeness of the sample, so it ceases to properly represent the population (Wright, Allen et al. 1995).

4.27 Establishing a clear benchmark or 'baseline' (to use American terminology) is vitally important in all forms of longitudinal service monitoring. It has to be clear where an individual was before they started contact with services, in order for service outcomes to be assessed.

4.28 Researchers in this field tend to recommend that considerable effort goes into recording as much contact information about a respondent as possible at first contact. This includes details of anywhere they are likely to be and, alongside contact details for friends and family, written permission that the researchers can show to friends or family members to reassure them that supplying information on someone's whereabouts is alright. Respondents are also issued with multiple means to contact the researchers, including cards, t-shirts and mugs with a freephone number and a freepost address. American studies have tracked people using the telephone, postal contact, data from service providers and through using teams of researchers looking in hostels and on the street. One group of US researchers noted that costs of maintaining contacts rise and fall depending on individuals' characteristics:

> "Simply put, the cheap methods locate the easy-to-find clients and the expensive methods locate the hard-to-find clients" (Wright, Allen et al. 1995, p. 276).

4.29 Although robust longitudinal surveys are the most accurate measurement of the sustainability of service outcomes, the costs and time consuming nature of this approach has

led to experiments with alternative methodologies. One alternative is to employ snapshot (one off) surveys after service contact has ceased.

4.30 This approach has been piloted in the US by re-running the same snapshot survey twice with the same respondents in a short period of time and then looking for inconsistencies in what they reported, essentially to see if reliance on memory produced varying results. If the same survey, relying on the same memories of the same people, produced inconsistent answers it meant that a one-off survey drawing on memory was probably inherently unreliable, because if people answered the same questions differently on two occasions, it was difficult to know whether either answer could be trusted. However, running the same survey on the same individuals a short time apart showed that respondents did answer in consistent ways (Tsemberis, McHugo et al. 2007). This enabled the researchers to conclude that a one-off survey reliant on memory was answered consistently, which suggested that reliance on memory for testing service outcomes might be both feasible and with the right design, sufficiently accurate. However, while this experiment was illuminating, the potential risk that people were consistently reporting the same inaccurate memory twice still needs to be borne in mind.

4.31 The final option relates to data sharing between services. In Edinburgh, the city council has developed its own comprehensive system for managing and reporting information on homeless people. The Homeless Information System (HIS) database is used to collect data on statutory activity, while the ECCO (Edinburgh Common Customer Outcomes) database maintained by the City is focused on data to support homeless strategy targets. The ECCO system is longitudinal, recording details of individual service users and service performance over time and was influential in the design of national-level Supporting People monitoring across Scotland[23]. Within the City, it could serve as a mechanism for assessing the sustainability of service outcomes for individuals and households, based on whether or not individuals reappeared in the system after apparently exiting homelessness. Ideally, these data would need to be combined with information on whether individuals had left the city, had died or been imprisoned, to increase confidence that long absences from the database were indeed evidence of successful outcomes.

4.32 This is obviously a limited approach in some respects, dependent as it is on service contact, as individuals might be struggling, or indeed have returned to homelessness, but not been picked up because they had not contacted a participating service provider. The more comprehensive data sharing between agencies is, the less the risks are of this happening.

4.33 There are both ethical and legal questions centred on the proper processing of personal data and under what circumstances any potentially personal information can be shared. Any information on service contact with homelessness or substance misuse services could disadvantage an individual in wider society. Free and informed consent should be obtained before any personal information was shared between services. This also applies to any data collection for outcome measurement. Service providers can, and do, refuse to participate in certain forms of data collection and data sharing. Recent research in England found that substance misuse services were often highly reluctant to routinely share data, because it would undermine their relationship with their service users if they knew information was being shared (Pleace and Bretherton 2006).

[23] http://www.edinburgh.gov.uk/

4.34 The practicality of outcome measurement relates to all the points discussed above. Whatever set of measures that is being proposed must be realistic and affordable, it must also be comprehensible to those who are completing the returns or information and it must be consistent. It has to be clear that those providing data for outcome measures are interpreting those measures in the same way, so that there is confidence that comparisons between services of the same type, or of all services, are valid.

4.35 Practicality is also determined by the administrative load that a set of outcome measures generates. If a dedicated, well resourced agency exists for the purpose of independent outcome monitoring, or a large pilot or comparative study is being conducted by a university, there is an opportunity to explore detail. Once this is not the case, for example when outcome monitoring must rely on services to complete returns of outcome indicators, detail cannot be pursued unless service providers receive specific funding to research, administer and complete returns.

4.36 Any one of the main issues in the outcome monitoring of services for homeless people with a history of substance misuse could be subject to *exhaustive* analysis. It is quite feasible to conduct two or three hour administered questionnaires looking at substance misuse alone, and similarly long and detailed outcome measures could be developed around the risks of homelessness and access to employment, education and training, as well as offending and anti-social behaviour.

4.37 The more detail is sacrificed, the less clear information there is on why services are succeeding or failing. The more detail there is, the more unwieldy and uneconomic the process of outcome measurement becomes. There is no straightforward answer as to what a proper balance is, compromises need to be made and that means more detail on one outcome means less detail on another.

4.38 Realism is very important in devising outcome measures. Homelessness and substance misuse are complex, varied and non-linear processes, they do not follow set pathways or set processes and the routes by which they are resolved may be equally varied. Crucially, in some instances, the most successful outcomes that are feasible may not be those which would 'ideally' be sought.

4.39 An outcome that results in someone with a history of homelessness, substance misuse and mental health problems taking up residence in permanent supported housing and living on benefit may not be 'ideal', but it may be the best that is achievable in relation to that specific individual. Evaluating service outcomes, by, for example, whether someone is living wholly independently, no longer involved in substance misuse and in paid work may simply not be setting a *realistic* target for some service users. 'Failure' in the Continuum of Care model in the US was in part attributable to the unrealistic goals that those services set themselves, just as the 'success' of Housing First is in part attributable to its more realistic objectives (see Chapter 3).

4.40 There is a de facto recognition of this reality in some of the current policy within Scotland. The closure of the long-stay traditional homeless hostels within Glasgow, as noted in Chapter Three, is being accomplished in part by the use of long-stay supported housing, although resettlement and the promotion of independent living in the community is also being used, when and where possible.

4.41 This does not, in any way, detract from the need to create services that aim to end substance misuse, end the risks of homelessness and help people recover from mental health problems. Independent living and a route out of social and economic exclusion through paid work must remain as goals, but they may not always be realistic service outcomes. Housing stability and harm reduction may be perfectly sensible goals for some individuals and some services.

4.42 The remainder of this chapter considers the best means by which to assess service outcomes for services working in this field. An overview of current outcome measures is given before detailed discussion of the measurement of homelessness prevention, substance misuse, health and well-being and an individual's social and economic position.

Developing service outcome measures

4.43 Draft outcome measures have been developed by the Homelessness and Substance Misuse Advisory Group (HSMAG). These draft relate to four areas of life for homeless people with history of substance misuse and are perhaps best viewed as a 'topic list' rather than a set of actual measures that could be used for data collection. The HSMAG areas for measurement are grouped around accommodation, drugs and alcohol, general health and wellbeing and social wellbeing. 'Headline' outcome measures, each constructed of several smaller indicators, have been developed for broad service outcomes (the HSMAG document is included as **Appendix 2** of this report):

- the service user should be living in accommodation that they feel to be safe, secure and appropriate to their needs;
- there should be a significant reduction in drug or alcohol related harm;
- there is a significant improvement in the overall health and well-being of the person;
- the person demonstrates effective social functioning (see Appendix 2).

4.44 Existing outcome indicators that are specifically designed for homelessness services use a very similar approach, using 'headline' outcomes that are composed of a series of smaller, more detailed, measures. The Supporting People[24] Outcomes Monitoring Framework for Scotland uses four very similar categories of "accommodation", "health" , "safety and

[24] Supporting People is a programme of funding designed to support a range of low intensity housing related services. Supporting People funding can be used for tenancy sustainment or resettlement services for homeless people or homelessness prevention and for the revenue costs of operating hostels, night-shelters, transitional housing and permanent supported housing. Ring-fenced budgets for local authorities were used for commissioning these services in Scotland and England, but the ring-fencing of these funds is about to end.

security", which covers anti-social behaviour and criminal activity by the service user as well as their own safety from crime, and "social and economic wellbeing"[25].

4.45 In England, the Supporting People outcome monitoring follows the same logic, with attention being focused on accommodation outcomes, social well-being, work and work-related activity, physical and mental health (including substance misuse) and on what is termed 'choice, control and confidence'. Again, there is also monitoring of anti-social behaviour and criminal activity[26].

4.46 The 'outcomes star', which was originally developed in London by St Mungos, also adopts the same basic approach. The focus is on outcomes in accommodation, economic activity, social well-being, management of substance misuse and physical and mental health (Figure 4.1).

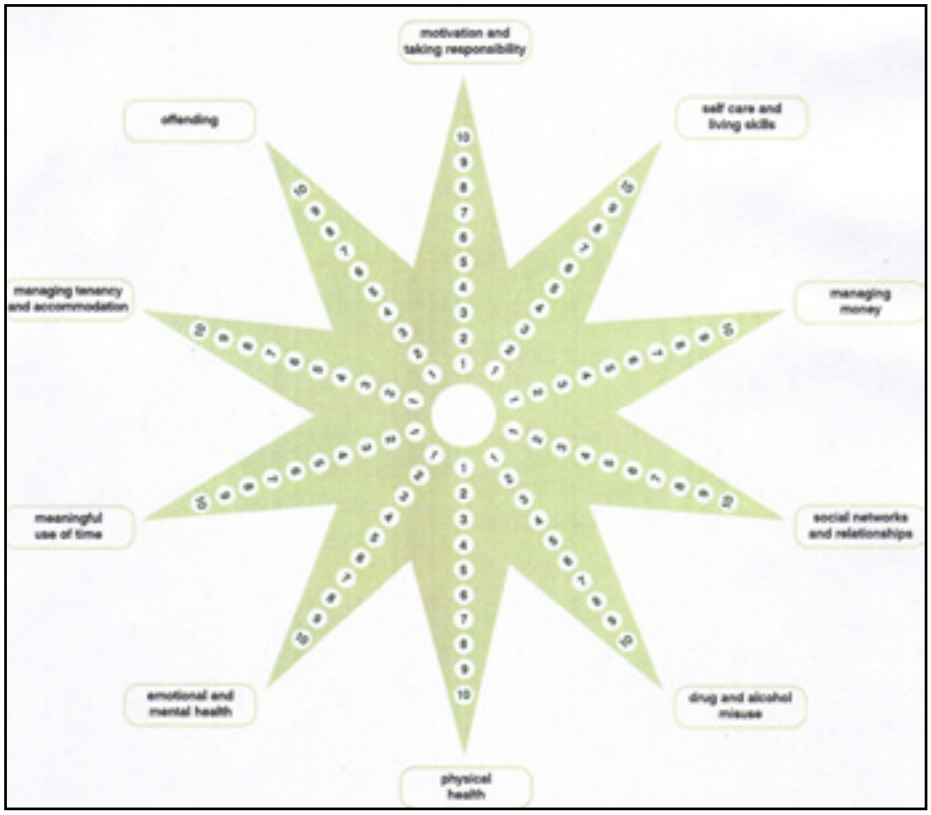


Figure 4.1: The Outcomes Star (source: London Housing Foundation[27]).

4.47 These various models are designed for use at the point at which service contacts stops. The record they create is a record of immediate service outcomes, not a record of service outcomes over time. One potential flaw with these models is therefore that they do not provide information on whether or not positive service outcomes are maintained. In the US,

[25] Supporting People Outcomes Scoring Matrix
http://www.scotland.gov.uk/Topics/Housing/Housing/supportpeople/SPoutscormat

[26] See: www.spkweb.org.uk/Subjects/Outcomes/

[27] http://www.lhf.org.uk/

with its convention of longitudinal monitoring, this would be seen as a fundamental flaw in design, because the overall effectiveness of services in producing lasting solutions is not being examined.

4.48 Some of these measures have potential limitations which are linked to the problem of collecting data on outcomes that are hard to define. These areas are sometimes called 'soft' outcomes because there is interpretation involved in what progress has been made, as opposed to 'hard' outcomes, e.g. a tenancy being sustained after 6 months, which is a simple and clear "yes/no" answer. Taking the outcomes star as an example, 'motivation and taking responsibility' and 'meaningful use of time' are, amongst others in the star, 'soft' indicators that can be potentially difficult to record because they can be ambiguous. What is good progress in 'motivation and taking responsibility' for one person may not be in another, a relatively small step for one individual may be hugely significant for another. In addition, there is the added complication that a worker is making an *interpretation* as to progress. Finally there may be a difficulty in deciding *exactly* what is meant by 'motivation' or 'taking responsibility' so the indicator is recording something that is consistently defined.

4.49 In the UK, a standard model for monitoring outcomes for substance misuse is the TOPS (Treatment Outcomes Profile) model, which is part of the National Drug Treatment Monitoring System (NDTMS) developed by the NHS. TOPS records substance misuse over the past four weeks. It also records whether a service user has been involved in various forms of crime including drug selling, shoplifting, other forms of theft and any form of violent crime. Finally, there is a record of the self-reported mental and physical health status of a service user, any paid work, education or training over the last four weeks and whether they are successfully sustaining accommodation. TOPS is designed to be used at the first point of contact with a service, during service delivery, at the end of service delivery and *after* service contact has ceased, allowing the creation of a longitudinal or time-series dataset[28].

4.50 Yet TOPS collects little data on housing issues. The sole indicator is one 'yes/no' tick box that records whether someone has an 'acute housing problem'. Other measures, like the Maudsley Addiction Profile (MAP)[29] or the Christo Inventory for Substance Misuse Services (CISS)[30], are also not designed with homeless or potentially homeless people in mind. There can too, be ambiguities about what is meant by substance misuse, for example methadone taken on prescription can be regarded as treatment, whereas street brought methadone use would tend to be regarded as 'misuse'.

4.51 There have been a series of American studies which have tested the viability of using statistical measures of substance misuse and mental health status intended for the general population on homeless people. There are, literally, dozens of such instruments. Without exception, these studies have shown that generalised survey instruments can work on the street and hostel dwelling populations that the US characterises as homeless (Sullivan, Dumenci et al. 2001).

[28] http://www.nta.nhs.uk/areas/outcomes_monitoring/docs/TOP_form_august_2007.pdf

[29] http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_346_MAP.pdf

[30] http://www.drugslibrary.stir.ac.uk/documents/christo.pdf

4.52 However, while these measuring instruments tend to work well with homeless people (or at least as well as they do on the general population), they may be too costly to administer and do not provide enough focus on homelessness issues.

4.53 There is also a reliance on service providers reporting using standardised web-based forms in the Supporting People monitoring for Scotland and England and within TOPS, with the attendant problems of potential data manipulation by the agencies completing returns. This criticism could be countered to an extent, by arguing that referral and assessment data can be combined with outcomes data to look for potential 'cherry picking' or other bias in service user selection, though these data are, of course, also collected through self-completion forms for service providers.

4.54 These systems are modest in scope and content and designed for practical use. They collect fairly small amounts of data and do not place unrealistic demands on agencies (though individual agencies might differ on their interpretation of how burdensome monitoring is). In addition, they are generalised sets of indicators, which allows outcome monitoring across service types.

4.55 The question of whether or not these indicators are too generic, not allowing for the nuance of individual types of services, or not recording smaller positive outcomes properly, needs to be considered. Beyond this, there is the issue of the accuracy and robustness of individual indicators. This can only be answered by looking at the detail of these monitoring systems, a process which is undertaken below.

4.56 All of these monitoring systems cover the same basic outcomes, although the attention that they pay to these outcomes varies. The broad 'headline' indicators used by the draft HSMAG outcome measures are a good summary of the focus of outcome indicators, that reflect the intended aims of all homelessness and substance misuse services to reduce substance misuse, promote socio-economic inclusion and place people into suitable housing that they can sustain. Some questions around the detailed measurement of service outcomes are now considered under the following headings:

- accommodation suitability and housing-related risks of homelessness;
- substance misuse;
- health and social well-being;
- economic inclusion;
- general well-being;
- programme fidelity, context and the trustworthiness of data.

4.57 Accommodation suitability covers several dimensions. Drawing on the evidence base and current practice in outcome measurement, the key factors by which suitability of accommodation should be judged are:

- an individual having exercised reasonable choice and control over where they live;
- privacy within accommodation;
- affordability;
- feeling safe in their own home and not being subject to bullying, harassment or other anti-social behaviour;
- not facing problems with housing conditions such as cold, overcrowding, damp, infestations or other issues;
- being in the correct location (this has several dimensions: being away from areas associated with illegal drug markets, proximity to social support networks and proximity to any required services and activities).

4.58 Risks of homelessness exist both for those people who have already had experience of homelessness and for those people who are at risk of becoming homeless. Good progress in the following areas is required, before *housing related* risks of homelessness can be judged as being overcome:

- accommodation is not at risk due to rent arrears, anti-social behaviour or criminal acts by the service user;
- there are no serious tensions between service users and other residents within supported housing and no serious tensions between service users and staff in supported housing;
- there is evidence that someone has the required daily living skills to manage in their accommodation setting, e.g. they can (where applicable) ensure bills are paid, feed themselves correctly and so forth.

4.59 These outcome measures are concerned with two aspects of accommodation-related risks that homelessness will occur or recur. The first set of risks is that the service user will *lose* their accommodation, centred on issues like daily living skills, rent arrears or anti-social behaviour. The second set of risks centre on factors that might cause a service user to *abandon* their accommodation, which might be the behaviour of those around them, harassment or being expected to follow many rules (see Chapter 3). Some indicators overlap, for example, someone might abandon accommodation to avoid paying rent arrears.

4.60 Existing systems of outcome monitoring tend to reflect the idea of a continuum or staircase model, which begins with a situation of homelessness and concludes with a situation of independent living. This approach could be criticised if the 'headline' indicator of a successful accommodation outcome was fully independent living, as this will not be a realistic goal in all cases (see Chapter 3).

4.61 However, if outcome monitoring is centred on accommodation being appropriate and sustainable, rather than attaching extra weight to specific tenures and living situations, outcome measures could become more realistic and flexible. For example, the HSMAG draft outcome measures note that while a Secure Scottish Tenancy is an ideal outcome, 'individually-identified ideal accommodation' can also be a good service outcome. This allows options such as permanent supported housing to be regarded as satisfactory outcomes, as and when appropriate (Appendix 2).

4.62 Risks to housing and the danger that a formerly or potentially homeless person might abandon accommodation are not static. Whether or not accommodation is settled can only be established by looking at accommodation outcomes over time. A service that places someone in accommodation that they will not sustain once that service is withdrawn is not producing a satisfactory outcome, this is something that cannot be established if outcome measures are only available up until the point that support ceases.

4.63 Example accommodation outcome measures are included as part of the draft **outcomes monitoring form**, which can be found in **Appendix 3.** The housing related measures are:

Does your accommodation have any of the following problems?

- cold
- damp
- poor heating
- infestation
- overcrowding
- not enough privacy
- poor repair
- too many rules and regulations/ do not get on with staff
- too far away from friends, family and/or services
- unsuitable neighbourhood

How would you rate your current accommodation out of 10 (where 1 is very bad and 10 is very good)?

Are you...

- in rent arrears (if yes by how many months)
- in arrears on electricity or gas bill
- in arrears on any other bills
- subject to verbal warning about anti-social behaviour

- subject to written warning about anti-social behaviour
- subject to verbal warning about damage to property
- subject to written warning about damage to property
- being told that you are going to be evicted/have to leave
- thinking of leaving because you are unhappy here

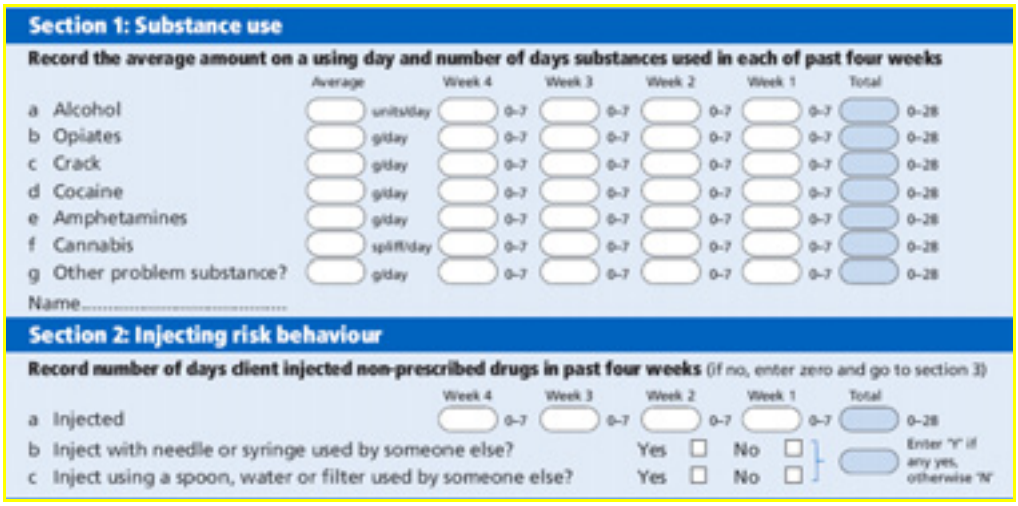
4.64 This list is simple and looks easy to record. However, the list and the example monitoring form in Appendix 3 also helps illustrate some of the problems that can arise with outcome monitoring. For example, if one confines questions to a list of specific problems with accommodation, there is a danger that the list would be too narrow. It may be that another factor, which is not listed above, is most important in terms of the suitability of housing. In addition, the terminology used here, while it may seem self-evident, needs to be clearly defined to ensure consistent and accurate measurement. What exactly is meant, for example by an 'infestation' and at what point should accommodation be regarded as 'damp' or 'cold'? Similarly, it might be argued that the categories under which risks of homelessness are examined, such as being subject to a verbal warning, may be incomplete or are ambiguous.

4.65 Outcome monitoring about risks of homelessness can be coupled with questions asking about *any* recent experience of homelessness. Example questions, focusing on issues such as sleeping rough, are included in the example outcomes monitoring form (Appendix 3). There might also be questions that can deal with whether or not an individual feels themselves to be at risk of homelessness or is judged to be at risk of homelessness.

Substance misuse

4.66 Outcome measures in relation to substance misuse record whether or not substance misuse has ceased and whether or not it is reducing or decreasing. The former is the basic measure of a successful outcome for abstinence based services, the latter is the more complex assessment of relative success used by harm reduction based services (see Chapter 3).

4.67 There are various ways of measuring outcomes. A good example is the TOPS form used as part of the National Drug Treatment Monitoring System (NDTMS) developed by the NHS. This longitudinal monitoring measure records the amount of substance use and associated risks (Figure 4.2).



Section 1: Substance use

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average		Week 4		Week 3		Week 2		Week 1		Total	
a Alcohol		units/day		0–7		0–7		0–7		0–7		0–28
b Opiates		g/day		0–7		0–7		0–7		0–7		0–28
c Crack		g/day		0–7		0–7		0–7		0–7		0–28
d Cocaine		g/day		0–7		0–7		0–7		0–7		0–28
e Amphetamines		g/day		0–7		0–7		0–7		0–7		0–28
f Cannabis		spliff/day		0–7		0–7		0–7		0–7		0–28
g Other problem substance?		g/day		0–7		0–7		0–7		0–7		0–28

Name.....

Section 2: Injecting risk behaviour

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and go to section 3)

	Week 4		Week 3		Week 2		Week 1		Total	
a Injected		0–7		0–7		0–7		0–7		0–28

b Inject with needle or syringe used by someone else? Yes ☐ No ☐

c Inject using a spoon, water or filter used by someone else? Yes ☐ No ☐

Enter 'Y' if any yes, otherwise 'N'

Figure 4.2: Substance misuse monitoring in the TOPS return[31].

4.68 Such measures are ideal for specific monitoring of substance misuse, but they may be too detailed and complex for some services to administer, particularly services led or provided by homelessness agencies. Alternative measures might include very simple questions as to whether or not illegal drug use, or harmful levels of alcohol consumption, have occurred over the last week, month or some other given period. However, this may not provide enough information on what the specific patterns of substance misuse are. There are also the concerns, detailed above and in Chapter 3, that aiming to put an end to substance misuse may be an unrealistic goal in some cases and that relative progress, i.e. harm reduction or harm minimisation, is not recorded by simple questions focused on whether or not substance misuse has stopped.

4.69 This is just one measure that might be used. Another example would be the AUDIT alcohol dependence scale or the Severity of Dependence (SDS) scale. Like the TOPS return, the SDS scale is short enough to be incorporated into general outcome measurement (see Figure 4.3).

[31] http://www.nta.nhs.uk/areas/outcomes_monitoring/docs/TOP_form_august_2007.pdf

	Never/ almost never	Sometimes	Often	Always/ nearly always
1. Do you think your use of (drug) was out of control?	0	1	2	3
2. Did the prospect of missing a fix (or dose) make you anxious or worried?	0	1	2	3
3. Did you worry about your use of (drug)?	0	1	2	3
4. Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
5. How difficult did you find it to stop or go without (drug)?	0	1	2	3

SDS TOTAL: _____

Figure 4.3: The SDS scale[32]

4.70 Another approach involves 'cherry picking' key indicators on substance misuse to minimise the administrative burden and complexity that can be associated with asking a longer, more detailed, series of questions. Some options are suggested in the example outcomes monitoring form (Appendix 3):

- had more than six drinks on one occasion (derived from AUDIT alcohol screening scale);
- felt you had a problem with drinking (derived from AUDIT alcohol screening scale);
- smoked cannabis, heroin or any other drug;
- injected heroin or any other drug;
- injected drugs with any equipment used by other people;
- taken speed or amphetamines or any other pills;
- Taken any other drugs that were not given to you by doctor/chemist;
- Which drugs have you taken? (If applicable).

[32] Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W., Strang, J. (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. *Addiction 90*(5): 607-614.

4.71 There is a potential problem with such an approach, as questions on substance misuse have been tested for accuracy alongside other questions in the same scale, but their validity as outcome measures, used on their own may either not be clear, or it may be inherently limited. For these reasons, it may be more practical to use a short scale from an existing, proven, means of measuring substance misuse levels, such as TOPS, or some combination of the AUDIT scale for alcohol and the SDS scale, for example.

4.72 Allowance has to be made for some services focusing on abstinence based approaches. As their criteria for success is different, these services need to be judged according to their specific goal to end substance misuse among their service users, harm reduction represents a "failure" for abstinence-based services.

4.73 It needs to be clear that harm reduction and/or abstinence are being sustained over time, otherwise service effectiveness cannot be properly judged.

Health and wellbeing

4.74 Physical and mental health can be subjected to a great deal of detailed analysis. Very extensive statistical instruments for assessing physical and mental health, such as the Scottish Health Survey, are used to assess health status. Such surveys are too large for deployment within service outcomes measurement. However, elements from within these questionnaires can be employed within outcomes monitoring.

4.75 Some options employing standardised health status questions from surveys used for the general population are suggested in the example outcomes monitoring form(Appendix 3):

> How is your health in general? Would you say it was… (from Scottish Health Survey[33])
>
> - Very good
> - Good
> - Fair
> - Bad
> - Very Bad
> - Don't know

[33] http://www.scotland.gov.uk/Publications/2005/11/25145024/50251

Would you say you are…(from British Household Panel Survey[34])

- Not anxious or depressed
- Moderately anxious or depressed
- Extremely anxious or depressed
- Don't know

4.76 Access to high quality social support is widely described as having benefits for physical and mental health (Cohen and Wills 1985; Callaghan and Morrisey 1993). Social support is usually measured according to the *types* of support that someone has available, which is sometimes coupled with data on who the source of support is. Data on the people that someone is in contact with are not usually seen as sufficient, i.e. contact with family may be in place, but relationships might be poor or destructive. There are longstanding concerns that people involved in substance misuse experience reductions in social networks that are damaging, e.g. the concern that drug users only know other drug users (Snow and Anderson 2001) or that former drug users only know other former drug users.

4.77 Social support is usually discussed in terms of either the 'buffer' theory in which social supports are held to have a positive effect when individuals are confronted with illness and stress, or the 'main effect' model, in which social supports are held to have a constant and generally beneficial effect (Cohen and Wills 1985; Callaghan and Morrisey 1993). A range of social resources are held to act against stress and in turn both reduce the likelihood of the onset of health problems and aid general well-being. Cohen and Wills (p.313) list:

- *esteem support*, information that a person is esteemed and accepted;
- *informational support*, help in defining, understanding and coping with problematic events;
- *social companionship*, spending time with others in leisure or recreational activities; and,
- *instrumental support*, the provision of financial aid, material resources and needed services.

4.78 Some options, including employing standardised questions from surveys used for the general population, are suggested in the example outcomes monitoring form(Appendix 3):

- someone you can really count on to listen to you when you need to talk (from British Household Panel Survey)[35]
- someone you can count on to help you out in a crisis (from BHPS)
- someone you can ask for information or advice when not sure what to do (from BHPS)

[34] http://www.iser.essex.ac.uk/ulsc/bhps/

[35] http://www.iser.essex.ac.uk/ulsc/bhps/

- friends you can spend time with
- family you can spent time with
- feel lonely or isolated

4.79 Again, there is the option to use an existing measure, such as the entire scale from a survey like the BHPS, but there may not always be scope to do this within the logistical constraints under which outcome monitoring has to operate. The concern that 'cherry picking' some questions from established measures and not employing the whole instrument exists in the same way as it does with questions on substance misuse. It needs to be clear that any questions that are used from existing instruments can function as outcome measures on their own.

4.80 The other dimension of social wellbeing relates to safety, crime and anti-social behaviour. Either experiencing or committing crimes or anti-social behaviour, particularly on a sustained basis, is indicative of social exclusion. Indicators about experience of anti-social behaviour and crime tend to be quite simple, focusing on recording whether or not someone has been a victim, a perpetrator or, as may quite often be the case with anti-social behaviour, both a victim and perpetrator (Jones, Pleace et al. 2006; Jones, Quilgars et al. 2006).

4.81 If someone feels unsafe in their home, there may be an increased chance that they will feel under pressure to abandon it. Equally, if someone is involved in crime or anti-social behaviour this could jeopardize their housing.

4.82 Some options for monitoring experience of crime and anti-social behaviour are suggested in the example outcomes monitoring form(Appendix 3):

Does your accommodation have any of the following problems?

- anti-social behaviour/ harassment from neighbours/other residents
- drug problems
- high crime rate

How safe do you feel when you are alone in your home at night? (derived from Scottish Household Survey)

- Very safe
- Fairly safe
- A bit unsafe
- Very unsafe
- Don't know

In the last three months have you?

- Been subject to a new or existing ASBO
- Been subject to a new or existing Acceptable Behaviour Contract
- Been cautioned
- Been arrested/fined or received custodial sentence
- Been in prison or young offenders institution
- Committed a petty offence, including receiving a warning from the Police or being fined

4.83 Again, longitudinal data are needed that confirm whether or not a service has produced or is producing sustainable solutions. Again, there is also the need to be clear that outcome measures have sufficient range and that what they are recording is as unambiguous as possible. There is also the question about whether or not tested measures from other outcome monitoring or surveys should be used and, if so, in what way.

Economic inclusion

4.84 Economic exclusion is defined as a lack of paid work and a lack of access to education, training and support that will facilitate access to paid work. A quite common acronym used to summarise economic exclusion is the term 'NEET', which denotes that someone is 'Not in Employment, Education or Training', which was originally designed to describe excluded young people.

4.85 Detailed analysis of access to education, training and work is possible, including lengthy exploration of the reasons why someone may face barriers to paid work, education. Many good examples of research and outcome evaluations focused on employment issues and employment services are funded by the Department for Work and Pensions[36]. Again, for practical reasons, there may be limits to the extent to which these issues can be explored in depth.

4.86 Some options for monitoring experience of crime and anti-social behaviour are suggested in the example outcomes measures (Appendix 3):

- Currently in paid work (full time)
- Currently in paid work (part time)
- Currently in training (part time)
- Currently in training (full time)
- Currently in education or further education (full time)

[36] http://www.dwp.gov.uk/resourcecentre/research_analysis_stats.asp

- Unemployed and seeking work
- Not able to work for health reasons
- Not seeking work due to childcare responsibilities
- Not seeking work because a full time carer (for an adult)
- Retired

4.87 Again, economic status may vary over time and may be subject to deterioration. It is again essential to try to monitor service outcomes over time.

4.88 A simple assumption that access to *any* paid employment will enhance quality of life or promote social inclusion may be questionable (see Chapter 3). There is a need to bear in mind the interrelationship between paid employment and other indicators of wellbeing. It is also important to bear in mind that paid work may not be a realistic option for some service users (see Chapter 3).

General wellbeing

4.89 Homelessness and substance misuse have a general impact on well-being. In the draft outcome measures suggested in Appendix 3, a question on general wellbeing is included. If general wellbeing is poor, then the overall outcome of a service intervention, can be viewed as limited. An indicator that might be used to monitor this outcome might look something like this, although as with the other examples given here, it is an illustration rather than something that is suggested as a finalised outcome measure:

Overall, how happy do you feel about life at the moment?

- Very happy
- Fairly happy
- Mixed feelings
- Not very happy
- Not at all happy
- Don't know

4.90 Poverty is strongly associated with both homelessness and substance misuse (see Chapter Two). Economic exclusion can also mean financial exclusion and difficulties in managing financially. Recent research on statutory homelessness among families and 16-17-year-olds in England found that general well-being, as common sense would suggest, was strongly associated with an individual's or household's financial situation (Pleace, Fitzpatrick et al. 2008). In the example outcome measures in Appendix 3, one measure of financial pressure employed by the British Household Panel Survey, is used as an illustrative example:

How well would you say you yourself are managing financially these days? Would you say you are (BHPS)

- Living comfortably
- Doing alright
- Just about getting by
- Finding it quite difficult
- Finding it very difficult
- Don't know

Collecting outcome monitoring data

4.91 Data collection for outcome monitoring can be undertaken in four basic ways. The first method is to survey service users using trained interviewers, which is an expensive option. The second method is to use key-workers and support workers whose primary role is service delivery, but who can be trained to use a structured questionnaire. This is cheaper, but it has the disadvantage that all the problems of keeping track of former service users fall into the lap of service providers whose primary role is service delivery. The third option is some form of self-completion survey, but for this to work longitudinally, efforts would still need to be made to ensure current addresses were held for former service users, and there would be the likelihood of a low response rate. The fourth mechanism is remote monitoring, by which for example, a service provider would be notified by a social landlord if a former service user went into rent arrears or abandoned a tenancy, or a substance misuse service would let a another former service provider know that a relapse had occurred. This approach involves no direct contact with a former service user, but it creates both ethical and legal issues around data sharing, privacy and data protection.

4.92 The collection of some outcome measures means dealing with potentially sensitive subjects. If outcomes monitoring is to be undertaken by people other than research professionals, particular care needs to go into the design of whatever form of data collection is used. If specific outcome monitoring for services working with homeless people with a history of substance misuse were developed, it would need to bear these issues in mind and would require piloting to ensure that it caused no distress, either to those collecting data or those supplying it.

4.93 The other issue to bear in mind has already been discussed. This is the question of 'soft' indicators and the judgement that is required whenever outcomes monitoring is attempted on something that cannot be answered with a simple, unambiguous yes/no question. A research professional may judge or interpret a response differently from a project worker and there may be a mismatch between what a person using a service thinks they have said and how that is interpreted. Careful piloting can help overcome the risk that a question is not properly defined, or is being interpreted in various ways by different people. This process is sometimes referred to as the 'cognitive testing' of questions.

Programme fidelity, context and the trustworthiness of data

4.94 Allowance for the effects of programme fidelity and context needs to be built into outcome measurement. Consideration also has to be given to the quality of data. However, it is important that the systems used are practical.

4.95 Programme fidelity can be measured quite simply in a broad sense. Guidance on what a service should include can, at a basic level, be contrasted with the evidence that this is what the service is delivering. This needs to be a separate exercise from outcomes monitoring, because it is actually concerned with processes of *service delivery*. It is about maintaining records about what has been provided, or is being provided, to each service user. The current mechanisms for monitoring Supporting People service delivery in England and Scotland are examples of this form of monitoring. This information needs to be available in a format that can be compared with the data on service outcomes. Again, Supporting People monitoring systems are designed to allow this.

4.96 The operational reality of services may be complex and much of what they do may not be recorded on statistical returns. Research or auditing may be required to check the degree to which statistical returns reflect actual process of service delivery. It needs to be ensured that services are following set patterns of service delivery that can be clearly associated with success or failure, rather than operating their own unique models.

4.97 Context can be measured in two ways. First, service providers and commissioners can be asked about issues like resources and interagency cooperation and joint working. If all the service providers in an area agree that resources are poor and coordination bad, or view these issues positively, this gives a reasonable estimation of the context in which services are operating. In addition, Scottish Government statistics on general economic conditions, housing and labour markets, levels of homelessness, waiting lists for social rented housing, and so forth, can help set specific services in a broad operational context.

4.98 Data trustworthiness is clearly enhanced if independent bodies are used for data collection and analysis on outcome measures. If this is not feasible, random auditing may help ensure that there is not inconsistency between what is being reported and what the outcomes are on the ground. Alongside the possibility of fraudulence, there is again the possibility that outcome measures are being widely misunderstood or that they are not accurately recording important activity, both of which can be addressed if there is auditing of outcome returns completed by service providers.

4.99 Data collection should, for reasons of accuracy, be longitudinal. The 'gold standard' outcome evaluations used in the US may be too expensive for Scotland and other methods may have to be explored. Some suggestions are made in the next chapter.

Summary

4.100 Effective outcome monitoring is not a simple exercise. Crude measures may not represent what a service is doing properly, while detailed outcome measures may not be feasible to administer because of the costs involved. Care must be exercised in ensuring that

realistic and clear objectives are set for services, which can be measured in systematic and comparable ways. The key areas for consideration are: accommodation suitability and risks of homelessness; substance misuse; health and social well-being; economic inclusion and general well-being. Allowance must be made for recording if services are following their original design or have modified it, to allow the validity of service models to be tested and ensure like is compared with like. Context can have a very significant impact on service operation, at a minimum, factors like local housing and labour markets and the availability of suitable housing need to be controlled for in outcome measurement. Longitudinal monitoring is the only way of ensuring whether service outcomes are sustained over time and accurately judging whether services are of lasting effectiveness.

5 Conclusions and recommendations

5.1 Homelessness associated with substance misuse is often seen as resulting from individual moral weakness, mental health problems, or some combination of the two (Lemere, Mossman et al. 1993; Dordick 1994; Mossman 1997; Neale 1997; Dordick 2002; Sahlin 2005; Carr 2006). Services have therefore been developed on the basis that substance misuse and homelessness have to be *treated* and that *corrections to individual behaviour* are also often necessary to overcome this social problem (see Chapter 3).

5.2 Services based on these ideas about the causation of homelessness associated with substance misuse have not performed particularly well in achieving the objectives they have set for themselves. The reasons for relative failure centre on placing too many demands on service users, not providing the right range of support and, in particular, in not recognising the breadth and complexity of needs (see chapters 2 and 3). These services are not outright failures, as they do meet with successes, but it is the case that they fail to engage with the bulk of the populations that they target.

5.3 Innovation in service delivery has resulted from a recognition of the complexity and extent of need among homeless people with substance misuse problems. Practice has also changed alongside the general movement away from abstinence and towards harm reduction and harm minimisation that has occurred across mainstream substance misuse services, which resulted in part from the relative failures of abstinence based services and the need for more effective measures to counteract the spread of HIV from sharing needles. This is reflected in services in other countries, like Pathways Housing First, and in much of the joint working to provide packages of support to homeless people with a history of substance misuse found across Scotland (see chapters 2 and 3).

5.4 There are strong arguments for aiming to maximise independence and the chances of entry into paid work for all homeless people with a history of substance misuse. A model like Pathways Housing First might be criticised on some levels for having more 'limited' goals and thus an easier to achieve standard of 'success', than a model that is intended to ensure abstinence and social and economic inclusion. The evidence base does suggest that fully independent living and sustained employment in paid work may not always be a practical goal for some homeless people with a history of substance misuse. However, more 'limited' outcomes, including harm reduction, sustainable housing, improved quality of life and generally increased stability can be achieved, even for highly vulnerable individuals with challenging behaviour. In addition, there is also evidence, from the studies of the Continuum model in the US, that abstinence based services can also be effective, even if only for a minority of homeless people with a history of substance misuse.

5.5 This suggests a need for a combination of services, reducing harm and stabilising tenancies where this is perhaps the best that can be achieved, but providing routes into paid work and sustainable abstinence for those who can achieve these goals with the right support. One type of hybrid service might be able to pursue either goal, based on detailed assessments and monitoring of progress, making a judgement as to when a service user has reached the best outcome that is realistic and when further work can be pursued. Joint working has the inherent flexibility to allow this sort of diverse outcome planning on a case-by-case basis,

though the provision of highly specialised support services may only be economically feasible in some of Scotland's larger cities or on a wide-area basis.

5.6 Outcome monitoring is essential to good service design and management. It is partially through the use of outcomes monitoring, particularly independent longitudinal studies that employed randomised control groups, that the US learned about the extent of relative failure in its Continuum of Care service model. The use of longitudinal evaluation also supported significant innovations in the US, particularly the RCT of the Pathways Housing First model.

5.7 The US has the resources to examine homelessness, welfare and health services employing costly, scientifically rigorous, methodologies. There has never been a full RCT of a homelessness service anywhere in the UK and there have only been a handful of attempts at any kind of longitudinal research, most of which have tended to be small, or underfunded, or both (Pleace and Quilgars, 2003a). Service evaluations of the scale and complexity of those conducted in the US may not currently be feasible within Scotland. If a government is spending many hundreds of millions of dollars to counteract a social problem an evaluation costing one or two million dollars seems quite logical. However, the cost of running a full, longitudinal RCT is more or less constant, this is because it has to be of a certain size and duration to be methodologically sound. This means that a full longitudinal RCT would still cost a similar amount in Scotland to those undertaken in America, an amount running well into hundreds of thousands of pounds, even if the costs of the programme it was evaluating were much lower than those of a US programme. Such an exercise would be seen by some people as misdirecting significant resources that could be better spent on service delivery. Nevertheless, the potential costs of not attempting more rigorous evaluations and longitudinal outcomes monitoring are significant, in particular there is a risk that ineffective or poorly performing services will be funded rather than better performing alternatives, due to a lack of clear evidence.

5.8 Outcome monitoring can be improved without having to use the most expensive methodology. A specific set of outcome indicators for homeless and potentially homeless people with a history of substance misuse can be developed. Some of the areas that such monitoring might cover are discussed in Chapter 4, though consideration would need to be given as to the merits of developing a separate system of monitoring against adding to or amending existing systems of outcome measurement and any new system would need to be carefully piloted and evaluated.

5.9 If outcomes monitoring can be made sufficiently cost effective to administer, there is a good case for attempting to either track service users over time on a wide area basis, or to use occasional longitudinal tracking of a representative sample (though this would still be expensive). Over time, data merging and data sharing across services may facilitate longitudinal tracking, but systems are likely to be restricted to specific areas and there are issues around privacy and data collection. Data merging of administrative records is also inherently limited because it is confined to contacts by services with individuals, which means the status of someone not currently in contact with a service cannot be determined.

5.10 As noted, the cost of failing to examine service outcomes over time could be that it is never clear that expenditure on services is being properly directed. It is arguable that longitudinal monitoring, or longitudinal surveys, may well be expensive, but that the lack of data on effectiveness that results may be much more expensive. America would have

continued to pursue the Continuum model if longitudinal data had not been available that raised questions about its validity as the only service response to substance misuse among homeless people.

5.11 It is far better to have sample-based longitudinal monitoring of service outcomes than to have global records of what the situation is at the point at which service contact *stops*. Recording service outcomes at the point services are withdrawn does not produce data on service effectiveness, *particularly and especially* in relation to enabling and sustaining independent living. Resources used for this purpose would often be better employed in creating and monitoring representative longitudinal samples of service users.

5.12 Ongoing monitoring of service users in permanent supported housing, or receiving ongoing floating support is also necessary, to ensure that these services are delivering the desired outcomes and maximising the quality of life of their service users.

5.13 These issues are quite distinct from monitoring service delivery. There need to be mechanisms to monitor all aspects of service delivery and to monitor programme fidelity, as if services are deviating from their original design it needs to be understood when and where this is happening. Ensuring services are delivering what they are commissioned to deliver is a separate exercise from determining whether or not they are producing good outcomes. The data from service delivery monitoring need to be combined with service outcome data to ensure that successes and failures are both monitored and understood.

5.14 Context must be allowed for. Outcomes in the service rich environments of Scotland's cities may be different from what is practical and achievable in rural areas. Innovation may be required, such as the use of 'regional' rather than local authority specific services for some groups of homeless people with a history of substance misuse.

5.15 The evidence reviewed here is not complete. There are many gaps in the evidence base or areas in which the only available research is of low quality[37]. Some of the more obvious gaps include there being little written evidence on the impact of the health and homelessness standards in Scotland. However, it should be noted that standards are at a relatively early operational stage and further work is planned by the Scottish Government to assess compliance and to provide feedback to Health Boards. Nor was there much discussion of substance misuse in homelessness strategies, although it is important to note that these homelessness strategies were written some time ago and there has been monitoring by the Scottish Government of local authorities work in this area through local outcome agreements and progress reports. Something that is conspicuous by its absence, despite some services like the Pathways model being focused on being user led, is any real evidence about what homeless people involved in substance misuse want or feel they need. This is a group of people without a clear voice in the literature on this subject and this may reflect their voices being generally absent from service planning and delivery.

5.16 Areas that might be specifically considered by future research include exploring the ways in which service users can be given a voice and the ways in which they might exercise more choice. Some of the evidence from the US suggests more choice and control leads to better service outcomes, while other evidence from the US and EU suggests that when choice is minimal, relative service failure can result. In addition, consideration might be given to

[37] See Pleace and Quilgars, 2003a for a critical discussion of homelessness research in the UK.

how best to monitor service outcomes longitudinally within Scotland, designing systems that both suit existing service operations and have realistic goals for data collection.

5.17 There are many areas of research that are closely interrelated to the subject discussed in this report. There are obvious links between general homelessness research and substance misuse research and what has been discussed here. However, both of these literatures are vast and are not directly concerned with the design, effectiveness and outcome monitoring of services *specifically* for homeless people with a history of substance misuse, which has been the focus of this report. There are other literatures that are also related, such as that focused on substance misuse services within prisons, which may deal both with formerly and potentially homeless people, but this literature does lie outside the specific remit of this report and is while it is broadly related, there was not scope to explore it in detail here.

5.18 A number of quite basic recommendations can be made, based on the evidence reviewed here and subject to the caveat that this evidence is not always complete or comprehensive. In summary, these recommendations are that:

- realistic service outcomes need to be set, these will be higher for some service users than others;
- harm reduction/harm minimisation models appear to meet with more success, though it needs to be borne in mind that their goals are more limited;
- the evidence base suggests a need for a mixture of services;
- longitudinal monitoring of service outcomes should be undertaken where possible;
- the evidence base suggests that service interventions may need to go on for some time, creating a need for a secure funding base;
- modification of generic services may be the best option in areas where numbers of homeless people with a history of substance misuse are low.

5.19 The arguments in favour of setting realistic service outcomes, the use of harm reduction/harm minimisation approaches and using a mixture of different service types where practicable have been explored above. The reasons for attempting to monitor service outcomes over time have also been discussed.

5.20 Most service models for homeless people with a history of substance misuse assume that the service will be able to offer support for quite long durations and in some instances on a long term basis. The one exception to this is short term detoxification, a model that has been experimented with but appears to have been largely or wholly abandoned due to a lack of success. This suggests there is a need for continuity of funding, rather than say an annual bidding or contracting round. Services aimed at homeless people with a history of substance misuse may need three or five year contracts, if not longer, to establish themselves and maintain positive service outcomes. This makes the need for effective monitoring of service delivery and service outcomes all the greater.

5.21 In areas in which the total level of homelessness is low, there is not always a strong case for developing specialised services for homeless people with a history of substance misuse or groups like homeless people with substance misuse problems and a severe mental illness. One option is to develop what might be termed ‘wide-area’ services. This can be

quite practical, if several local authorities cooperate to fund specialised floating support and there are examples of such homeless services across Scotland. However, there are logistical limits to the areas that a team of mobile workers can be expected to cover. This will particularly be the case in some parts of rural Scotland where the journey time between towns and villages is long and for those local authority areas that cover several separate islands. There may also be scope to develop wide-area shared fixed-site services that provide specialist support, but these are relatively expensive, difficult to expand or contract if the estimate of need is incorrect and become impractical if service users have to travel long distances.

5.22 In those circumstances where it may not be practical to develop a floating support service or a fixed-site service, the best option may be to seek to modify existing services for homeless people and people with a history of substance misuse. In many areas of Scotland, joint working is already in place between these services, but there may be scope to further the awareness of substance misuse in homelessness services and the awareness of homelessness in substance misuse services. Minor alterations to services may also be practical, for example allocating part of the time of a substance misuse worker to homeless people and developing a small, dedicated resource through that route. Interagency working on this issue may also heighten awareness, improve recording and demonstrate the need for some form of specialist resource. There may too be scope for resource sharing, for example more rural and suburban authorities or areas that contain one or two larger towns or cities could work towards cross-authority referral when this was appropriate.

5.23 The main message from this review is that outcomes for homeless people with a history of substance misuse can be improved. There are means available to make a positive change to their lives and also reduce the risks and costs that might otherwise arise both for homeless people themselves and for Scottish society. The successes that can be achieved will be limited in some respects and it is important to always be realistic about what can be attained, however, there are service models that can demonstrably improve outcomes for homeless people with a history of substance misuse. It is also possible to develop means by which to measure service outcomes, to ensure that success are achieved and maintained over time.

Appendix 1: Research methods

A.1 Table A1 shows the databases and other resources that were searched for the review. Initially, two broad searches were conducted. The first was a search conducted using the definitions agreed with the research advisory group. The second search was very broad and included *all references* that included the terms 'Scotland' and 'homelessness' alongside associated phrases[38]. The reason for this second search was to ensure that any and all research concerned with homelessness in Scotland that was of potential relevance was included in the REA review.

Table A1: Resources searched

Resource type
Homelessness **charities** and **voluntary organizations** in **Scotland**
Scottish housing associations
Scottish local authority websites (including homelessness strategies)
NHS Scotland and NHS Health Scotland websites
Scottish Government website
Communities Scotland website
Resources and **reports** from other **national governments** in the **UK**
MEDLINE (primary global abstracting and indexing service for the medical science)
EMBASE (covers 3,500 biomedical and pharmaceutical related journals)
PsycINFO (global database run by the American Psychological Association)
HMIC (Department of Health and King's Fund covering official publications on health and social care)
Sociological Abstracts (global academic database)
Social Services Abstracts (current research in social work, human services, and related topics)
Criminal Justice Abstracts (comprehensive coverage of criminology and related areas)
PAIS International (international literature on social and public policy including government publications)
The Cochrane Library (systematic reviews of healthcare effectiveness)
Social Policy& Practice (database containing over 200,000 publications, of all types, on social policy)
Social Science Citation Index (fully indexes more than 1,725 journals across 50 social sciences disciplines)
Social Care Online (free resource which aims to be the UK's most extensive social care database)
C2-SPECTR (registry of over 10,000 randomized and possibly randomized trials in welfare and public policy)

A.2 The two broad searches used basic terms, e.g. 'homeless' and 'homelessness' were employed in combination linked terms, e.g. and/or 'alcohol' and/or 'drugs' and/or 'substance'. Any studies that mention these terms were included. If one begins a search by using a term like 'young people' alongside the terms related to homelessness and substance misuse, then only those studies that include any reference to 'young people' would be included. Using these broader search term means that any and all studies that include any reference to substance misuse among any and all groups of homeless people, including young people, are included.

A.3 The review was focused on countries that were broadly comparable with Scotland. This included the EU, other European countries, Australasia, Japan, North America and England, Wales and Ireland (including Northern Ireland). Other countries were not included because comparison with Scotland is inherently problematic on a number of levels. This international review employed international databases that cover reports and papers written in

[38] For example, 'Scottish' and 'homeless' and also any reference to major cities like Aberdeen, Edinburgh, Glasgow or specific regions, such as 'Highland' that also mentioned homelessness.

many languages. These databases also provide abstracts (i.e. summaries) of all the publications they contain that are written in English These English summaries made it possible to determine whether a paper or report written in another language was potentially relevant and a translated version of that publication could then be ordered (provision was made in the research budget for translation). In practice, only small number of papers written in European languages were included in the review because they were relevant to the topic. The single largest source of research and related information specifically focused on substance misuse and homelessness was the United States, this was followed by the work produced in Scotland and England, with studies from EU countries, Japan and Australasia being less common. The bulk of the most rigorous and systematic work was from the US and the only examples of longitudinal Randomised Control Trials (RCTs) were from the US. The databases searched encompassed medical, social and homelessness research as well as related policy documents.

A.4 During the 1980s a literature that had been focused on the relationships between alcohol misuse and homelessness began to switch its attention to the relationships between drug misuse and general substance misuse and homelessness. For this reason, the review encompasses only a few studies that focused simply on homeless people with alcohol misuse problems after about 1980. This is not because research on this specific subject, rather than substance misuse in general, became less common after that date.

A.5 The scope of the review, including the subjects it was *not designed to encompass* are described in Chapter 1.

A.6 The ***basic*** searches conducted for the REA review produced the following results, which were stored as two main databases of references in the bibliographic and reviewing software *Endnote*.

- Database 1: 5,537 studies, reports and pieces of guidance that made reference to homelessness and substance misuse.
- Database 2: 1,108 studies, reports and pieces of guidance that made any reference to homelessness and homeless people in Scotland.

A.7 These two databases are records of all the references in all the resources that were searched (as shown in Table A1). Creating these two databases allowed the research team to simultaneously and quickly search all the references from any of the resources shown in Table A1 that might be relevant to the REA review. Each of the two databases of references constructed for the REA review contains details of the authors, title and publication information for each publication. The two databases contain abstracts, or summaries, of each piece of research. It is these abstracts that the research team searched to look for pieces of work in the 6,645 references that were collected in databases 1 and 2, that were of direct relevance to the research questions.

A.8 Table A2 shows the sub-topics that were explored in detail within the two databases that were created from the basic searches. As can be seen, references dealing with prevention, the specific needs and experiences of different groups of homeless people and service effectiveness and outcome measures were sought out by the research team.

Table A2: Sub-topics

Topics
Prevalence and nature of substance misuse
Associations between drug/alcohol use and causes of homelessness
Prevention of drug/alcohol use
Prevention of homelessness linked to drug/alcohol use
Models of service delivery
Effective service delivery
Cost effectiveness
Understanding barriers to services
Studies focused on homeless young people
Studies focused on homeless families and children
Studies focused on women
Studies focused on people sleeping rough
Studies focused on people with a ethnic minority background
Good practice
Strategic planning
Social inclusion (tenancy sustainment, employment, education, training)
Effective outcome measurement
Models of outcome measurement
Longitudinal assessment of service outcomes over time

A.9 If a study was judged to be potentially relevant based on its abstract, then the full text was ordered to be read and assessed by the research team. A judgement is then made as to whether or not a publication warrants inclusion in the review. The criteria for selecting studies for inclusion within the REA method is based on the principles of a systematic review, concentrating on securing the best available evidence and including only those studies that have a robust methodology.

A.10 Table A3, below, shows the criteria that were used when determining which studies should be included in the review. As can be seen, publications are assessed according to a mixture of 'desirable' and 'essential' criteria. The REA review could not simply focus on Scotland as this would have yielded little research in respect of some subject areas. Thus, while a focus on Scotland was 'desirable', it was not always 'essential' for a study to be included. Similarly, one of the key tests in assessing the robustness of research is whether or not a study has been subject to peer review.

A.11 However, much homelessness research, including work conducted in Scotland, has not been subject to peer review because it was conducted by consultants, internally by various branches of national or local government or by the voluntary or charitable sectors. Only allowing publications that had been peer reviewed would have excluded some robust studies that were worthy of conclusion in the research and was thus only a desirable rather than an essential criteria for inclusion.

Table A3: Criteria for Inclusion in the Review

Criteria	Desirable	Essential
Scottish research or good practice guidance	√	
Direct focus on drugs, alcohol and/or multiple needs		√
Direct focus on one or more forms of homelessness		√
Peer-reviewed or based upon peer-reviewed research	√	
If not reporting on Scotland, reports on comparable countries		√
Research question clearly stated		√
Theoretical or ideological perspective of authors/funders explicit	√	
Study design is clear and appropriate to the question		√
Context or setting adequately described		√
Sample adequate and drawn from appropriate population		√
Adequate data collection		√
Evidence of rigorous analysis		√
Findings supported by evidence and consideration given to data limitations		√
Any claims that results can be applied generally are well supported		√
Ethical questions have been considered and properly addressed		√

A.12 When considering research for inclusion it was not possible to compromise in respect of the other criteria shown in Table A2. Research had to include a focus on homelessness and substance misuse (this could be alongside other subjects), i.e. it had to deal directly with the issues the review was concerned with, rather than, for example, be confined simply to substance misuse in the general population without any reference to homeless people. Research that was not about Scotland also had to be broadly applicable to Scotland, i.e. be from broadly comparable countries in the UK or elsewhere. A research study need not employ the most elaborate and robust methods available for its results to be useful, but at the same time it cannot lack a clear focus or employ dubious or unclear methodology. There is no exact 'tipping point' at which a study either becomes, or ceases to be, 'robust', but it should under most circumstances fulfil, or be based upon, studies that fulfil the criteria for acceptance shown in Table A3.

A.13 One exception was made in relation to the criteria shown in Table A3. This exception was good practice guidance that had been produced that was either closely or directly related to the focus of the REA review. Often, while it may partially draw on research, good practice guidance will be informed by a other factors, including current practice in services that, while judged to be effective, have not been formally and independently evaluated. As a central concern of the research was current thinking in terms of what constitutes an effective service and how service effectiveness should be measured, it was of central importance that relevant guidance on service delivery and outcome monitoring was also included in the REA review.

Detail on searches conducted

A.14 The core search strategy used was as follows:

1. exp Homeless Persons/
2. homeless$.ti,ab.
3. (houseless or roofless).ti,ab.
4. destitut$.ti,ab.
5. skid row.ti,ab.
6. (street adj (people or person$ or youth$ or child or children)).ti,ab.
7. (sleep$ adj3 rough).ti,ab.
8. ((emergency or temporary) adj accommodation).ti,ab.
9. ((insecure or overcrowded) adj accommodation).ti,ab.
10. "bed and breakfast".ti,ab.
11. shelter$.ti,ab.
12. (hostel or hostels or refuge or refuges).ti,ab.
13. squatt$.ti,ab.
14. or/1-13
15. exp Substance-Related Disorders/
16. ((substance$ or drug$ or narcotic$) adj2 (abuse$ or misuse or dependen$ or addict$ or habit$)).ti,ab.
17. ("drug use" or drug user$).ti,ab.
18. addict$.ti,ab.
19. (injector or injecting or intravenous or IDU).ti,ab.
20. chemical$ dependen$.ti,ab.
21. dependence disorder$.ti,ab.
22. drug involved.ti,ab.
23. exp Street Drugs/
24. ((street or illicit or illegal or recreational) adj drug$).ti,ab.
25. designer drugs/
26. ((designer or customized or customised) adj drug$).ti,ab.
27. exp Amphetamines/ or exp Cocaine/ or exp Analgesics, Opioid/ or Heroin/ or Phencyclidine/ or Morphine/
28. (amphetamin$ or cocaine or crack or opioid or opiate$ or heroin$ or phencyclidine or morphine).ti,ab.
29. Cannabis/
30. (cannabis or marijuana or marihuana).ti,ab.
31. Ketamine/ or exp Hallucinogens/ or N-Methyl-3,4-methylenedioxyamphetamine/ or Lysergic Acid Diethylamide/ or Methadone/ or Methamphetamine/
32. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth$).ti,ab.
33. or/15-32
34. Alcohol Drinking/
35. exp Alcoholic Beverages/
36. (alcohol$ or drink$ or liquor$ or beer$ or wine$ or absinthe or spirits or alco pops).ti,ab.
37. (drunk$ or intoxicat$ or binge).ti,ab.
38. (inebriant or inebriate$).ti,ab.
39. or/34-38
40. 14 and (33 or 39)
41. limit 40 to yr="1970 - 2007"

A.15 This strategy was designed for searching MEDLINE through the Ovid interface and was adapted as appropriate for all other databases searched, taking into account differences in indexing terms and search syntax for each database.

A.16 Mindful of the time and resources available for this review, the searches were limited to identify papers published from 1970 onwards. Full details of all databases searched and search strategies are provided below:

MEDLINE: Ovid (http://gateway.ovid.com/athens)

A.17 The MEDLINE search covered the date range 1970 to October 2007 (Week 3). The search was carried out on 31 October 2007 and identified 2214 records.

1.exp Homeless Persons/ (4369)
2.homeless$.ti,ab. (4040)
3.(houseless or roofless).ti,ab. (7)
4.destitut$.ti,ab. (127)
5.skid row.ti,ab. (97)
6.(street adj (people or person$ or youth$ or child or children)).ti,ab. (277)
7.(sleep$ adj3 rough).ti,ab. (20)
8.((emergency or temporary) adj accommodation).ti,ab. (19)
9.((insecure or overcrowded) adj accommodation).ti,ab. (5)
10."bed and breakfast".ti,ab. (16)
11.shelter$.ti,ab. (3509)
12.(hostel or hostels or refuge or refuges).ti,ab. (1383)
13.squatt$.ti,ab. (673)
14.or/1-13 (10337)
15.exp Substance-Related Disorders/ (168191)
16.((substance$ or drug$ or narcotic$) adj2 (abuse$ or misuse or dependen$ or addict$ or habit$)).ti,ab. (39994)
17.("drug use" or drug user$).ti,ab. (23525)
18.addict$.ti,ab. (24067)
19.(injector or injecting or intravenous or IDU).ti,ab. (184697)
20.chemical$ dependen$.ti,ab. (1104)
21.dependence disorder$.ti,ab. (172)
22.drug involved.ti,ab. (141)
23.exp Street Drugs/ (5856)
24.((street or illicit or illegal or recreational) adj drug$).ti,ab. (5240)
25.designer drugs/ (448)
26.((designer or customized or customised) adj drug$).ti,ab. (342)
27.exp Amphetamines/ or exp Cocaine/ or exp Analgesics, Opioid/ or Heroin/ or Phencyclidine/ or Morphine/ (115482)
28.(amphetamin$ or cocaine or crack or opioid or opiate$ or heroin$ or phencyclidine or morphine).ti,ab. (105910)
29.Cannabis/ (5784)
30.(cannabis or marijuana or marihuana).ti,ab. (9659)
31.Ketamine/ or exp Hallucinogens/ or N-Methyl-3,4-methylenedioxyamphetamine/ or Lysergic Acid Diethylamide/ or Methadone/ or Methamphetamine/ (36871)
32.(ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth$).ti,ab. (20790)
33.or/15-32 (502486)
34.Alcohol Drinking/ (35353)
35.exp Alcoholic Beverages/ (8948)
36.(alcohol$ or drink$ or liquor$ or beer$ or wine$ or absinthe or spirits or alco pops).ti,ab. (202987)
37.(drunk$ or intoxicat$ or binge).ti,ab. (33326)
38.(inebriant or inebriate$).ti,ab. (118)
39.or/34-38 (236360)
40.14 and (33 or 39) (2240)
41.limit 40 to yr="1970 - 2007" (2214)

EMBASE: Ovid (http://gateway.ovid.com/athens)

A.18 The EMBASE search covered the date range 1980 to 2007 (Week 43). The search was carried out on 31 October 2007 and identified 2031 records.

1. homelessness/ (3026)
2. homeless$.ti,ab. (2987)
3. (houseless or roofless).ti,ab. (6)
4. destitut$.ti,ab. (73)
5. skid row.ti,ab. (50)
6. (street adj (people or person$ or youth$ or child or children)).ti,ab. (213)
7. (sleep$ adj3 rough).ti,ab. (23)
8. ((emergency or temporary) adj accommodation).ti,ab. (17)
9. ((insecure or overcrowded) adj accommodation).ti,ab. (3)
10. "bed and breakfast".ti,ab. (12)
11. shelter$.ti,ab. (2405)
12. (hostel or hostels or refuge or refuges).ti,ab. (902)
13. squatt$.ti,ab. (560)
14. or/1-13 (7036)
15. substance abuse/ (17658)
16. exp Drug Abuse/ (40388)
17. exp drug dependence/ or exp narcotic dependence/ (37740)
18. ((substance$ or drug$ or narcotic$) adj2 (abuse$ or misuse or dependen$ or addict$ or habit$)).ti,ab. (34949)
19. "drug use"/ (39767)
20. ("drug use" or drug user$).ti,ab. (22211)
21. addiction/ (4681)
22. addict$.ti,ab. (21315)
23. (injector or injecting or intravenous or IDU).ti,ab. (156813)
24. chemical$ dependen$.ti,ab. (748)
25. dependence disorder$.ti,ab. (166)
26. drug involved.ti,ab. (141)
27. street drug/ or illicit drug/ or recreational drug/ (5305)
28. ((street or illicit or illegal or recreational) adj drug$).ti,ab. (5194)
29. designer drug/ (254)
30. ((designer or customized or customised) adj drug$).ti,ab. (356)
31. Amphetamine/ or Cocaine/ or Opiate/ or Diamorphine/ or Phencyclidine/ or Morphine/ (107867)
32. (amphetamin$ or cocaine or crack or opioid or opiate$ or heroin$ or phencyclidine or morphine).ti,ab. (97918)
33. Cannabis/ or cannabis smoking/ (10301)
34. (cannabis or marijuana or marihuana).ti,ab. (8065)
35. Ketamine/ or Psychedelic Agent/ or 3,4 Methylenedioxymethamphetamine/ or Lysergide/ or Methadone/ or Methamphetamine/ (37876)
36. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth$).ti,ab. (17410)
37. or/15-36 (407404)
38. Drinking Behavior/ (9298)
39. Alcohol/ or exp alcoholic beverage/ (91958)
40. alcohol abuse/ (11308)
41. alcoholism/ (37779)
42. Alcohol Consumption/ (35170)
43. (alcohol$ or drink$ or liquor$ or beer$ or wine$ or absinthe or spirits or alco pops).ti,ab. (176900)
44. alcohol intoxication/ or drug intoxication/ or drunkenness/ (12392)
45. (drunk$ or intoxicat$ or binge).ti,ab. (26374)

46. (inebriant or inebriate$).ti,ab. (110)
47. or/38-46 (257903)
48. 14 and (37 or 47) (2031)

PsycINFO: Ovid (http://gateway.ovid.com/athens)

A.19 The PsycINFO search covered the date range 1970 to October 2007 (Week 4). The search was carried out on 01 November 2007 and identified 2071 records.

1. exp homeless/ (3472)
2. homeless$.ti,ab. (4450)
3. (houseless or roofless).ti,ab. (4)
4. destitut$.ti,ab. (89)
5. skid row.ti,ab. (132)
6. (street adj (people or person$ or youth$ or child or children)).ti,ab. (385)
7. (sleep$ adj3 rough).ti,ab. (21)
8. ((emergency or temporary) adj accommodation).ti,ab. (7)
9. ((insecure or overcrowded) adj accommodation).ti,ab. (3)
10. "bed and breakfast".ti,ab. (5)
11. shelters/ (583)
12. shelter$.ti,ab. (3456)
13. (hostel or hostels or refuge or refuges).ti,ab. (948)
14. squatt$.ti,ab. (102)
15. or/1-14 (8485)
16. exp drug usage/ (89613)
17. ((substance$ or drug$ or narcotic$) adj2 (abuse$ or misuse or dependen$ or addict$ or habit$)).ti,ab. (34214)
18. ("drug use" or drug user$).ti,ab. (17032)
19. addict$.ti,ab. (20027)
20. (injector or injecting or intravenous or IDU).ti,ab. (5373)
21. chemical$ dependen$.ti,ab. (1598)
22. dependence disorder$.ti,ab. (202)
23. drug involved.ti,ab. (127)
24. exp narcotic drugs/ (15921)
25. ((street or illicit or illegal or recreational) adj drug$).ti,ab. (4065)
26. ((designer or customized or customised) adj drug$).ti,ab. (59)
27. amphetamine/ or exp cocaine/ (11669)
28. (amphetamin$ or cocaine or crack or opioid or opiate$ or heroin$ or phencyclidine or morphine).ti,ab. (35229)
29. exp cannabis/ (2615)
30. (cannabis or marijuana or marihuana).ti,ab. (7345)
31. ketamine/ or exp hallucinogenic drugs/ or methylenedioxymethamphetamine/ or methamphetamine/ (5168)
32. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth$).ti,ab. (8247)
33. or/16-32 (140193)
34. exp Alcoholic Beverages/ (1267)
35. (alcohol$ or drink$ or liquor$ or beer$ or wine$ or absinthe or spirits or alco pops).ti,ab. (73208)
36. (drunk$ or intoxicat$ or binge).ti,ab. (9543)
37. (inebriant or inebriate$).ti,ab. (88)
38. or/34-37 (78031)
39. 15 and (33 or 38) (2089)
40. limit 39 to yr="1970 - 2007" (2071)

HMIC: Ovid (http://gateway.ovid.com/athens)

A.20 The HMIC search covered the date range 1970 to November 2007. The search was carried out on 01 November 2007 and identified 255 records.

1. homelessness/ (1531)
2. homeless$.ti,ab. (1456)
3. (houseless or roofless).ti,ab. (6)
4. destitut$.ti,ab. (15)
5. skid row.ti,ab. (2)
6. (street adj (people or person$ or youth$ or child or children)).ti,ab. (5)
7. (sleep$ adj3 rough).ti,ab. (74)
8. exp temporary accommodation/ (33)
9. ((emergency or temporary) adj accommodation).ti,ab. (59)
10. ((insecure or overcrowded) adj accommodation).ti,ab. (1)
11. exp "bed and breakfast accommodation"/ (159)
12. "bed and breakfast".ti,ab. (83)
13. shelter/ (10)
14. shelter$.ti,ab. (520)
15. hostels/ or refuges/ (200)
16. (hostel or hostels or refuge or refuges).ti,ab. (467)
17. squatters/ (4)
18. squatt$.ti,ab. (8)
19. or/1-18 (2740)
20. exp substance abuse/ (4925)
21. exp substance abusers/ (747)
22. ((substance$ or drug$ or narcotic$) adj2 (abuse$ or misuse or dependen$ or addict$ or habit$)).ti,ab. (1927)
23. ("drug use" or drug user$).ti,ab. (5754)
24. addict$.ti,ab. (587)
25. intravenous drugs/ (79)
26. (injector or injecting or intravenous or IDU).ti,ab. (566)
27. chemical$ dependen$.ti,ab. (20)
28. dependence disorder$.ti,ab. (2)
29. drug consumption/ (419)
30. drug involved.ti,ab. (7)
31. exp "drugs of abuse"/ (753)
32. ((street or illicit or illegal or recreational) adj drug$).ti,ab. (252)
33. designer drugs/ (2)
34. ((designer or customized or customised) adj drug$).ti,ab. (4)
35. (amphetamin$ or cocaine or crack or opioid or opiate$ or heroin$ or phencyclidine or morphine).ti,ab. (452)
36. (cannabis or marijuana or marihuana).ti,ab. (217)
37. hallucinogens/ or methadone/ (69)
38. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth$).ti,ab. (191)
39. or/20-38 (10607)
40. alcohol consumption/ (988)
41. alcohol related problems/ (70)
42. (alcohol$ or drink$ or liquor$ or beer$ or wine$ or absinthe or spirits or alco pops).ti,ab. (3553)
43. drunkenness/ (32)
44. (drunk$ or intoxicat$ or binge).ti,ab. (233)
45. (inebriant or inebriate$).ti,ab. (1)
46. or/40-45 (3799)
47. 19 and (39 or 46) (255)

48. limit 47 to yr="1970 - 2007" (255)

Sociological Abstracts: CSA Illumina http://www.csa1.co.uk/csaillumina/login.php

A.21 The Sociological Abstracts search covered the date range 1970 to date. The search was carried out on 01 November 2007 and identified 561 records. This strategy was entered using the 'Command Search'. The Date Range was set to '1990 to 2008'.

1. KW=homeless* (2573)
2. KW=(houseless or roofless) (8)
3. KW=destitut* (187)
4. KW=skid row (83)
5. KW=(street people or street person* or street youth* or street child or street children) (318)
6. KW=(sleep* within 3 rough) (15)
7. KW=(emergency accommodation or temporary accommodation) (11)
8. KW=(insecure accommodation or overcrowded accommodation) (0)
9. KW="bed and breakfast" (1)
10. KW=shelter* (1405)
11. KW=(hostel or hostels or refuge or refuges) (585)
12. KW=squatt* (444)
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 (4745)
14. KW=(substance* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (2392)
15. KW=(drug* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (4387)
16. KW=(narcotic* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (88)
17. KW=(drug use or drug user*) (4401)
18. KW=addict* (2233)
19. KW=(injector or injecting or intravenous or IDU) (621)
20. KW=chemical* dependen* (104)
21. KW=dependence disorder* (9)
22. KW=drug involved (43)
23. DE=("drugs" or "narcotic drugs") (938)
24. KW=(street drug* or illicit drug* or illegal drug* or recreational drug*) (1003)
25. KW=(designer drug* or customized drug* or customised drug*) (8)
26. KW=(amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (2093)
27. KW=(cannabis or marijuana or marihuana) (1335)
28. DE=("psychedelic drugs" or "lysergic acid diethylamide") (54)
29. KW=(ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth*) (535)
30. #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 (10734)
31. KW=(alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco pops) (10225)
32. KW=(drunk* or intoxicat* or binge) (1287)
33. KW=(inebriant or inebriate*) (31)
34. #31 or #32 or #33 (10643)
35. #13 and (#30 or #34) (561)

Social Services Abstracts: CSA Illumina http://www.csa1.co.uk/csaillumina/login.php

A.22 The Social Services Abstracts search covered the date range 1979 to date. The search was carried out on 01 November 2007 and identified 568 records. This strategy was entered using the 'Command Search'.

1. KW=homeless* (1734)
2. KW=(houseless or roofless) (5)
3. KW=destitut* (49)
4. KW=skid row (22)
5. KW=(street people or street person* or street youth* or street child or street children) (169)
6. KW=(sleep* within 3 rough) (18)
7. KW=(emergency accommodation or temporary accommodation) (5)
8. KW=(insecure accommodation or overcrowded accommodation) (0)
9. KW="bed and breakfast" (0)
10. KW=shelter* (1004)
11. KW=(hostel or hostels or refuge or refuges) (138)
12. KW=squatt* (171)
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 (2683)
14. KW=(substance* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (3502)
15. KW=(drug* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (3861)
16. KW=(narcotic* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (28)
17. KW=(drug use or drug user*) (2967)
18. KW=addict* (1978)
19. KW=(injector or injecting or intravenous or IDU) (658)
20. KW=chemical* dependen* (223)
21. KW=dependence disorder* (13)
22. KW=drug involved (43)
23. DE=("drugs" or "narcotic drugs") (271)
24. KW=(street drug* or illicit drug* or illegal drug* or recreational drug*) (511)
25. KW=(designer drug* or customized drug* or customised drug*) (1)
26. KW=(amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (26)
27. KW=(cannabis or marijuana or marihuana) (511)
28. DE=("psychedelic drugs" or "lysergic acid diethylamide") (19)
29. KW=(ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth*) (508)
30. #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 (8345)
31. KW=(alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco pops) (4957)
32. KW=(drunk* or intoxicat* or binge) (412)
33. KW=(inebriant or inebriate*) (14)
34. #31 or #32 or #33 (5035)
35. #13 and (#30 or #34) (568)

Criminal Justice Abstracts: CSA Illumina http://www.csa1.co.uk/csaillumina/login.php

A.23 The Criminal Justice Abstracts search covered the date range 1970 to 2008. The search was carried out on 02 November 2007 and identified 294 records. This strategy was entered using the 'Command Search'. The Date Range was set to '1990 to 2008'.

1. KW=homeless* (434)
2. KW=(houseless or roofless) (0)
3. KW=destitut* (15)
4. KW=skid row (35)
5. KW=(street people or street person* or street youth* or street child or street children) (102)
6. KW=(sleep* within 3 rough) (5)
7. KW=(emergency accommodation or temporary accommodation) (2)
8. KW=(insecure accommodation or overcrowded accommodation) (0)
9. KW="bed and breakfast" (3)
10. KW=shelter* (627)
11. KW=(hostel or hostels or refuge or refuges) (179)
12. KW=squatt* (13)
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 (1239)
14. KW=(substance* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (2044)
15. KW=(drug* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (4331)
16. KW=(narcotic* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (223)
17. KW=(drug use or drug user*) (2912)
18. KW=addict* (2295)
19. KW=(injector or injecting or intravenous or IDU) (215)
20. KW=chemical* dependen* (82)
21. KW=dependence disorder* (5)
22. KW=drug involved (121)
23. DE="drugs" (4375)
24. KW=(street drug* or illicit drug* or illegal drug* or recreational drug*) (1138)
25. KW=(designer drug* or customized drug* or customised drug*) (9)
26. KW=(amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (1927)
27. KW=(cannabis or marijuana or marihuana) (1153)
28. KW=(ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth*) (531)
29. #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 (9411)
30. KW=(alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco pops) (4887)
31. KW=(drunk* or intoxicat* or binge) (1520)
32. KW=(inebriant or inebriate*) (61)
33. #30 or #31 or #32 (5558)
34. #13 and (#29 or #33) (294)

PAIS: CSA Illumina http://www.csa1.co.uk/csaillumina/login.php

A.24 The PAIS International search covered the date range 1972 to date. The search was carried out on 02 November 2007 and identified 103 records. This strategy was entered using the 'Command Search'.

1. KW=homeless* (833)
2. KW=(houseless or roofless) (0)
3. KW=destitut* (34)
4. KW=skid row (9)
5. KW=(street people or street person* or street youth* or street child or street children) (120)
6. KW=(sleep* within 3 rough) (4)
7. KW=(emergency accommodation or temporary accommodation) (2)
8. KW=(insecure accommodation or overcrowded accommodation) (0)
9. KW="bed and breakfast" (1)
10. KW=shelter* (722)
11. KW=(hostel or hostels or refuge or refuges) (247)
12. KW=squatt* (184)
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 (1924)
14. KW=(substance* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (409)
15. KW=(drug* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (2165)
16. KW=(narcotic* within 2 (abuse* or misuse or dependen* or addict* or habit*)) (93)
17. KW=(drug use or drug user*) (526)
18. KW=addict* (1020)
19. KW=(injector or injecting or intravenous or IDU) (91)
20. KW=chemical* dependen* (14)
21. KW=dependence disorder* (0)
22. KW=drug involved (11)
23. DE=("drugs" or ="narcotics") (1935)
24. KW=(street drug* or illicit drug* or illegal drug* or recreational drug*) (383)
25. KW=(designer drug* or customized drug* or customised drug*) (6)
26. KW=(amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (738)
27. KW=(cannabis or marijuana or marihuana) (317)
28. DE=(="hallucinogenic drugs" or "lysergic acid diethylamide") (0)
29. KW=(ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth*) (88)
30. #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 (4841)
31. KW=(alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco pops) (3542)
32. KW=(drunk* or intoxicat* or binge) (283)
33. KW=(inebriant or inebriate*) (0)
34. #31 or #32 or #33 (3629)
35. #13 and (#30 or #34) (103)

The Cochrane Library: Internet http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME)

A.25 Issue 2007/4 of The Cochrane Library was searched on 02 November 2007. The search identified: 63 reviews on the **Cochrane Database of Systematic Reviews**. The results were scanned and 9 potentially relevant records were downloaded. Fifteen reviews on the **Database of Abstracts of Reviews of Effects (DARE)**. The results were scanned and 9 potentially relevant records were downloaded.

1. MeSH descriptor Homeless Persons explode all trees (148)
2. homeless* (336)
3. houseless or roofless (0)
4. destitut* (6)
5. skid NEXT row (2)
6. (street NEXT (people or person* or youth* or child or children)) (11)
7. sleep* NEAR/3 rough (1)
8. ((emergency or temporary) NEXT accommodation) (5)
9. ((insecure or overcrowded) NEXT accommodation) (0)
10. "bed and breakfast" (2)
11. shelter* (178)
12. hostel or hostels or refuge or refuges (55)
13. squatt* (82)
14. (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13) (589)
15. MeSH descriptor Substance-Related Disorders explode all trees (6234)
16. ((substance* or drug* or narcotic*) NEAR/2 (abuse* or misuse or dependen* or addict* or habit*)) (4633)
17. ("drug use" or drug NEXT user*) (2220)
18. addict* (7632)
19. (injector or injecting or intravenous or IDU) (39329)
20. chemical* NEXT dependen* (56)
21. dependence NEXT disorder* (25)
22. drug NEXT involved (38)
23. MeSH descriptor Street Drugs explode all trees (143)
24. ((street or illicit or illegal or recreational) NEXT drug*) (443)
25. MeSH descriptor Designer Drugs, this term only (2)
26. ((designer or customized or customised) NEXT drug*) (8)
27. MeSH descriptor Amphetamines explode all trees (804)
28. MeSH descriptor Cocaine explode all trees (511)
29. MeSH descriptor Analgesics, Opioid explode all trees (9176)
30. MeSH descriptor Heroin, this term only (200)
31. MeSH descriptor Phencyclidine, this term only (8)
32. MeSH descriptor Morphine, this term only (2735)
33. (amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (13018)
34. MeSH descriptor Cannabis, this term only (214)
35. (cannabis or marijuana or marihuana) (951)
36. MeSH descriptor Ketamine, this term only (677)
37. MeSH descriptor Hallucinogens explode all trees (448)
38. MeSH descriptor N-Methyl-3,4-methylenedioxyamphetamine, this term only (55)
39. MeSH descriptor Lysergic Acid Diethylamide, this term only (46)
40. MeSH descriptor Methadone, this term only (650)
41. MeSH descriptor Methamphetamine, this term only (108)
42. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal NEXT meth*) (2816)
43. (#15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42) (60641)
44. MeSH descriptor Alcohol Drinking, this term only (1482)
45. MeSH descriptor Alcoholic Beverages explode all trees (241)
46. (alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco NEXT pops) (14004)
47. (drunk* or intoxicat* or binge) (2136)
48. (inebriant or inebriate*) (15)
49. (#44 OR #45 OR #46 OR #47 OR #48) (15198)

50. (#14 AND (#43 OR #49)) (291)

Social Policy and Practice: ARC2 WebSPIRS (http://arc.uk.ovid.com)

A.26 The Social Policy and Practice search covered the date range 1970 to 200710. The search was carried out on 09 Novemberl 2007 and identified 686 records.

1. homeless* in TI,AB,DE (6186)
2. (houseless or roofless) in TI,AB,DE (10)
3. destitut* in TI,AB,DE (74)
4. skid row in TI,AB,DE (3)
5. (street people or street person* or street youth* or street child or street children) in TI,AB,DE (67)
6. (sleep* near3 rough) in TI,AB,DE (507)
7. (emergency accommodation or temporary accommodation) in TI,AB,DE (789)
8. (insecure accommodation or overcrowded accommodation) in TI,AB,DE (15)
9. (bed and breakfast) in TI,AB,DE (338)
10. shelter* in TI,AB,DE (2721)
11. (hostel or hostels or refuge or refuges) in TI,AB,DE (1210)
12. squatt* in TI,AB,DE (86)
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 (9271)
14. ((substance* or drug* or narcotic*) near2 (abuse* or misuse or dependen* or addict* or habit*)) in TI,AB,DE (4950)
15. (drug use or drug user*) in TI,AB,DE (1230)
16. addict* in TI,AB,DE (1283)
17. (injector or injecting or intravenous or IDU) in TI,AB,DE (149)
18. chemical* dependen* in TI,AB,DE (42)
19. dependence disorder* in TI,AB,DE (3)
20. drug involved in TI,AB,DE (12)
21. (street drug*or illicit drug* or illegal drug* or recreational drug*) in TI,AB,DE (142)
22. (designer drug* or customized drug* or customised drug*) in TI,AB,DE (1)
23. (amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) in TI,AB,DE (455)
24. (cannabis or marijuana or marihuana) in TI,AB,DE (200)
25. (ketamine or hallucinogens or ecstasy or LSD or methadone or crystal meth*) in TI,AB,DE (167)
26. (alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or alco pops) in TI,AB,DE (3622)
27. (drunk* or intoxicat* or binge) in TI,AB,DE (191)
28. (inebriant or inebriate*) in TI,AB,DE (3)
29. #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 (7750)
30. #13 and #29 (695)
31. #13 and #29 and (PY:1M = 1970-2007) (686)

Social Science Citation Index: MIMAS Web of Knowledge (http://wok.mimas.ac.uk)

A.27 The Social Science Citation Index search covered the date range 1970 to date. The search was carried out on 09 November 2007 and identified 1783 records. Limits were set at the beginning of the search for 'Timespan=1990-2007'.

1. TS=homeless* (5328)
2. TS=(houseless or roofless) (13)
3. TS=destitut* (205)

4. TS="skid row" (164)
5. TS=("street people" or "street person*" or "street youth*" or "street child" or "street children") (508)
6. TS=(sleep* SAME rough) (40)
7. TS=("emergency accommodation" or "temporary accommodation") (15)
8. TS=("insecure accommodation" or "overcrowded accommodation") (3)
9. TS="bed and breakfast" (22)
10. TS=shelter* (3304)
11. TS=(hostel or hostels or refuge or refuges) (1049)
12. TS=squatt* (584)
13. #12 OR #11 OR #10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1 (9898)
14. TS=((substance* or drug* or narcotic*) SAME (abuse* or misuse or dependen* or addict* or habit*)) (30014)
15. TS=("drug use" or "drug user*") (19097)
16. TS=addict* (16340)
17. TS=(injector or injecting or intravenous or IDU) (6041)
18. TS="chemical* dependen*" (777)
19. TS="dependence disorder*" (142)
20. TS="drug involved" (124)
21. TS=("street drug*" or "illicit drug*" or "illegal drug*" or "recreational drug*") (3769)
22. TS=("designer drug*" or "customized drug*" or "customised drug*") (55)
23. TS=(amphetamin* or cocaine or crack or opioid or opiate* or heroin* or phencyclidine or morphine) (23897)
24. TS=(cannabis or marijuana or marihuana) (7138)
25. TS=(ketamine or hallucinogens or ecstasy or LSD or methadone or "crystal meth*") (6975)
26. #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 (73413)
27. TS=(alcohol* or drink* or liquor* or beer* or wine* or absinthe or spirits or "alco pops") (68304)
28. TS=(drunk* or intoxicat* or binge) (7839)
29. TS=(inebriant or inebriate*) (68)
30. #29 OR #28 OR #27 (72096)
31. #26 AND #13 (1490)
32. #30 AND #13 (868)
33. #32 OR #31 (1783)

Social Care Online (http://www.scie-socialcareonline.org.uk/)

A.28 The Social Care Online search covered the date range 1986 to date. The search was carried out on 13 November 2007 and identified 208 records. The feature 'Browse social care topics' was used to identify the appropriate topic terms on which to search.

> @k=("homeless*" or "rough sleepers" or "bed and breakfast" or "temporary accommodation" or "hostels" or "refuges" or "supported housing") AND @k=("substance misuse" or "addiction" or "alcohol misuse" or "detoxification" or "drug misuse" or "solvent misuse")

C2-SPECTR: Internet (http://geb9101.gse.upenn.edu/)

A.29 The C2-SPECTR search covered the date range from inception to 02-17-2005. The search was carried out on 13 November 2007 and identified 23 records. Using the advanced search and searching in the field 'all non-indexed fields':

{homeless} or {houseless} or {roofless} or {destitut} or {skid row} or {street people} or {street person} or {street youth} or {street child} or {sleeping rough} or {rough sleeper} or {emergency accommodation} or {temporary accommodation} or {insecure accommodation} or {overcrowded accommodation} or {breakfast} or {shelter} or {hostel} or {refuge} or {squatt}

AND

{substance} or {drug} or {narcotic} or {addict$} or {injector} or {injecting} or {intravenous} or {IDU} or {chemical dependen} or {dependence disorder} or {amphetamin} or {cocaine} or {crack} or {opioid} or {opiate} or {heroin} or {phencyclidine} or {morphine} or {cannabis} or {marijuana} or {marihuana} or {ketamine} or {hallucinogens} or {ecstasy} or {LSD} or {methadone} or {crystal meth} or {alcohol} or {drink} or {liquor} or {beer} or {wine} or {absinthe} or {spirits} or {alco pops} or {drunk} or {intoxicat$} or {binge} or {inebriant} or {inebriate}

Organisational websites

A.30 In addition to the electronic databases, searches of the following organisational websites were carried out.

- Shelter (www.shelter.org.uk) The Shelter website search was carried out on 04-12-2007. Details of 13 potentially relevant documents were added to the Endnote library.
- Drugscope (www.drugscope.org.uk/) The Drugscope website search was carried out on 05-12-2007. Details of three potentially relevant documents were added to the endnote library. The Drugscope database 'DrugData' was also searched on 05-12-2007. The search was limited to find book chapter and monograph materials, as numerous databases had already been searched yielding journal articles. The search consisted of a search for the term 'homelessness' as a thesaurus term. Details of 32 potentially relevant documents were added to the Endnote Library.
- National Institute on Drug Abuse (NIDA) (www.nida.nih.gov/) The NIDA website search was carried out on 06-12-2007. No relevant documents were identified.

- Shared Learning on Homelessness (www.sharedlearnings.org/). The Shared Learning on Homelessness website search was carried out on 06-12-2007. No relevant documents were identified.
- CRASH/JRF Review of Single Homelessness Research (http://www.crashindex.org.uk/) The Review of Single Homelessness Research website search was carried out on 06-12-2007. Details of eight potentially relevant documents were added to the Endnote Library.
- FEANSTA (http://www.feantsa.org/code/en/hp.asp) The Review of Single Homelessness Research website search was carried out on 07-12-2007. Details of seven potentially relevant documents were added to the Endnote Library.

Appendix 2: HSMAG draft outcome measures

OUTCOME AREA 1 – ACCOMMODATION

THE SERVICE USER SHOULD BE LIVING IN ACCOMMODATION THAT THEY FEEL TO BE SAFE, SECURE AND APPROPRIATE TO THEIR NEEDS

Potential indicators:

- Person has privacy and independence
- Person understands the range of housing options available to them and is happy with their current arrangements
- Person is reasonably confident that they won't become homeless again
- If in accommodation in their own right, has a formal occupancy agreement of some sort that they understand & that outlines their rights & responsibilities
- Accommodation does not unreasonable restrict contact &/or relationship with significant others, unless service user agrees to this as part of planned approach
- Accommodation circumstances no longer contribute to risk of drug or alcohol use/relapse
- Appropriate support is available to the person in their accommodation
- Geographical location of accommodation suits service users' needs as far as possible – service user understands and accepts the compromise involved in this

Example Continuum – noted that continuums would need to be individually tailored

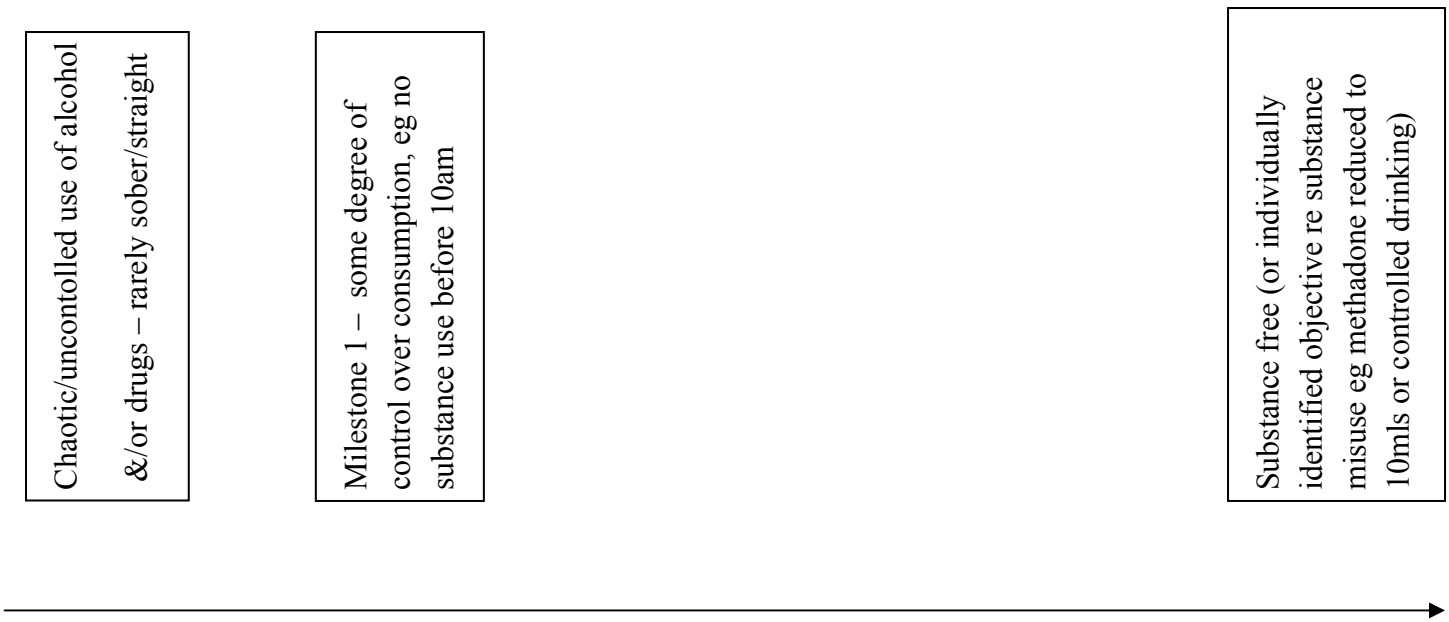
OUTCOME 2 – DRUGS AND ALCOHOL

THERE SHOULD BE A SIGNIFICANT REDUCTION IN DRUG OR ALCOHOL RELATED HARM

Potential Indicators

- There is a sustained and purposeful engagement with services, including clear continuity of care and easy access to support
- IV (intravenous) use stopped
- Reduction/stopping of chaotic or uncontrolled substance use
- Service user proactive in own treatment/care plan
- Significant reduction in drug/alcohol driven offending behaviour
- Drug & alcohol related issues no longer contribute to risk of homelessness

Example Continuum



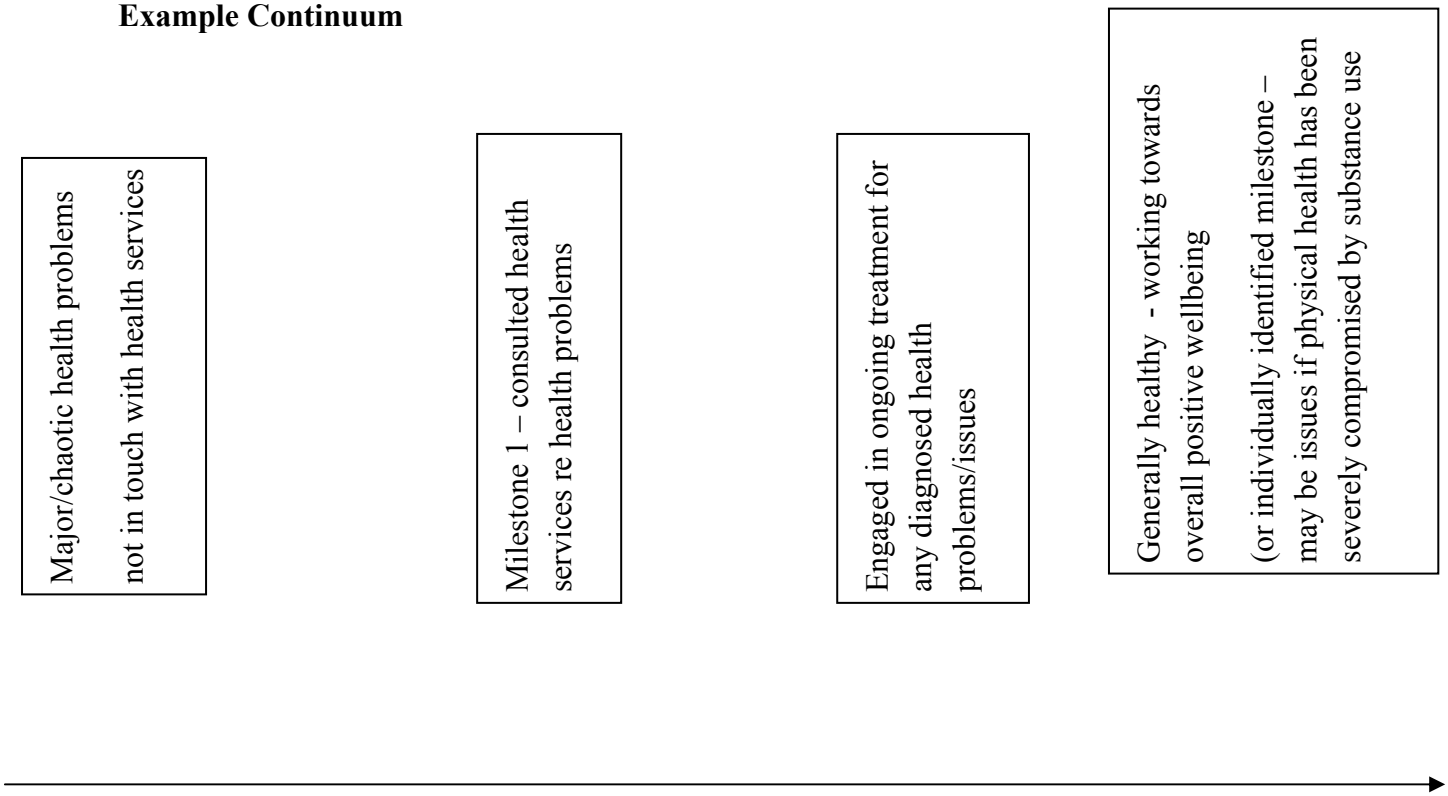
OUTCOME 3 – GENERAL HEALTH & WELLBEING

THERE IS A SIGNIFICANT IMPROVEMENT IN THE OVERALL HEALTH AND WELLBEING OF THE PERSON

Potential Indicators

- there is a reduction in physical health symptoms related to alcohol or drug use
- protects self from Blood borne viruses or if BBV+ has access to & engages in treatment and adapts behaviour to ensure protection of others
- improved nutrition – weight gain
- improved dental health
- receiving counselling/support &/or treatment re mental health symptoms
- reduction in mental health symptoms
- sexual health checked & engaged in any necessary treatment – sexual behaviour safe

Example Continuum



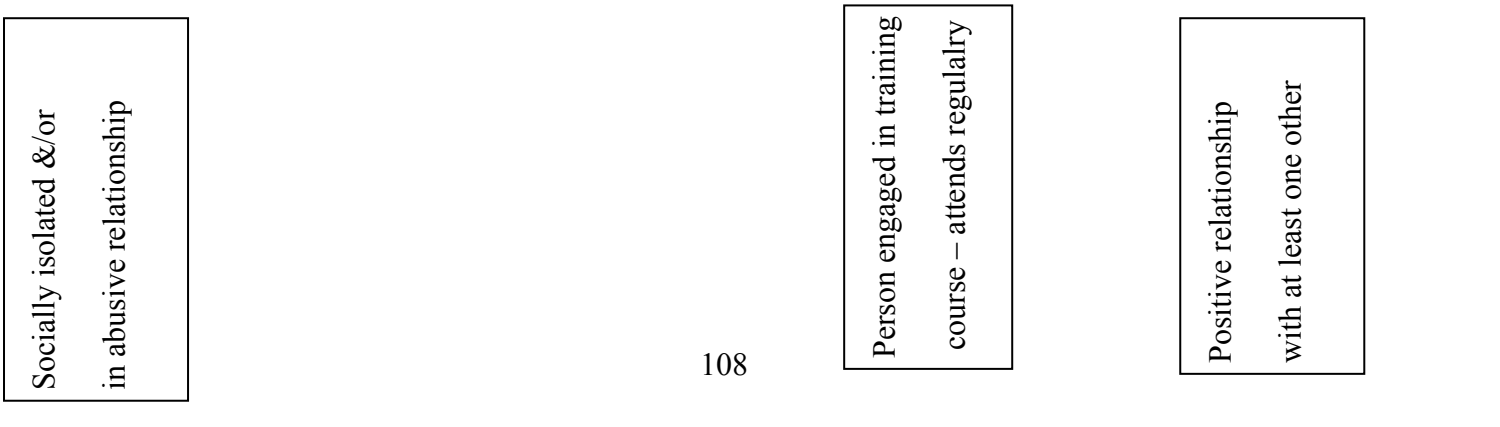
OUTCOME 4 - SOCIAL WELLBEING

PERSON DEMONSTRATES EFFECTIVE SOCIAL FUNCTIONING

Potential Indicators

- Improved relationships with partner/family/friends
- Part of a social network
- Person has significant others in their life
- Person is engaged in meaningful activity, eg volunteering, education, training, employment, pre-employment activity
- Person manages their money effectively
- Reduced or no offending behaviour
- If a parent, they have either care of their children, positive contact with their children, or are coping with lack of contact.
- The needs of the service user's children have been clearly assessed and are being met
- The service user is working positively with relevant support services.

Example Continuum



Appendix 3: Example outcome measure

Service outcomes return (illustrative example)

Date:	
Location:	[Code for Service]

Name		☐ M ☐ F	**DOB:**	
Status:	☐ Single (no children) ☐ Partnered (no children) ☐ Single (children) ☐ Partnered (children) ☐ Divorced ☐ Widowed			
Ethnic origin (self defined):		**National Insurance number**		
Service user code: [system code]				
Current address:				
Current type of accommodation	☐ social rented (council or housing association) ☐ private rented ☐ owner occupied ☐ friends or relatives ☐ hostel ☐ B&B ☐ sleeping rough ☐ squatting ☐ car ☐ caravan or tent			

Time in current accommodation	☐ Up to 1 month	☐ 4-5 months	☐ 2-3 years	☐ 6-7 years	
	☐ 2-3 months	☐ 6-12 months	☐ 3-4 years	☐ 8-9 years	
	☐ 3-4 months	☐ 1-2 years	☐ 5-6 years	☐ 10 years or more	

Experience of homelessness

	Ever in life	In last year	In last 3 months	In last month
Slept rough	☐	☐	☐	☐
Stayed in homeless hostel or night-shelter	☐	☐	☐	☐
Stayed with friends/ relatives because you had no home of your own	☐	☐	☐	☐
Lived in a squat	☐	☐	☐	☐
Lived in a car	☐	☐	☐	☐
Lived in a caravan or tent	☐	☐	☐	☐

Experience of substance misuse [OR SUBSITITUTE EXISTING SUBSTANCE MISUSE SCALE]

	Ever in life	In last year	In last 3 months	In last month
Had more than six drinks on one occasion	☐	☐	☐	☐
Felt you had a problem with drinking	☐	☐	☐	☐
Smoked cannabis heroin or other drugs	☐	☐	☐	☐
Injected heroin or any other drug	☐	☐	☐	☐
Injected drugs with any equipment used by someone else	☐	☐	☐	☐
Taken speed or amphetamines or any other pills	☐	☐	☐	☐
Taken any other drugs that would not be given to you by doctor/chemist	☐	☐	☐	☐
Which drugs have you taken? (If applicable)				

Social support [OR SUBSITITUTE EXISTING SCALE]

	Yes	No
Someone you can really count on to listen to you when you need to talk (BHPS)	☐	☐
Someone you can count on to help you out in a crisis (BHPS)	☐	☐
Someone you can ask for information or advice when not sure what to do (BHPS)	☐	☐
Friends you can spend time with	☐	☐
Feel lonely or isolated	☐	☐

Activity		
	Yes	No
Currently in paid work (full time)	☐	☐
Currently in paid work (part time)	☐	☐
Currently in training (part time)	☐	☐
Currently in training (full time)	☐	☐
Currently in education or further education (full time)	☐	☐
Unemployed and seeking work	☐	☐
Not able to work for health reasons	☐	☐
Not seeking work due to childcare responsibilities	☐	☐
Not seeking work because a full time carer (for an adult)	☐	☐
Retired	☐	☐

Health and well-being	
How is your health in general? Would you say it was… (SHS)	Would you say you are…(BHPS)
☐ Very good	☐ Not anxious or depressed
☐ Good	☐ Moderately anxious or depressed
☐ Fair	☐ Extremely anxious or depressed
☐ Bad	☐ Don't know
☐ Very Bad	
☐ Don't know	

Housing issues		
Does your accommodation have any of the following problems?	Are you...	
☐ Cold	☐ in rent arrears	if yes, by ..... Months
☐ Damp	☐ in arrears on electricity or gas bill	
☐ Poor heating	☐ in arrears on any other bills	
☐ Infestation	☐ subject to verbal warning about anti-social behaviour	
☐ Overcrowded	☐ subject to written warning about anti-social behaviour	
☐ Not enough privacy	☐ subject to verbal warning about damage to property	
☐ Poor repair	☐ subject to written warning about damage to property	
☐ anti-social behaviour/ harassment from neighbours/other residents	☐ being told that you are going to be evicted/have to leave	
☐ drug problems	☐ thinking of leaving because you are unhappy here	
☐ high crime rate		
☐ too many rules and regulations/ do not get on with staff	How would you rate your current accommodation out of 10 (where 1 is very bad and 10 is very good)?	
☐ too far away from friends, family and/or services		

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